

THERAPISTS' CONSTRUCTIONS OF PRACTICE IN
RELATION TO WOMEN EXPERIENCING ORGASM
DIFFICULTY: A FOUCAULDIAN DISCOURSE ANALYSIS

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ABSTRACT

The aim of this thesis is to explore how clinicians construct their practice with women experiencing difficulty with orgasm, by adopting a Foucauldian Discourse Analysis (FDA).

In the first part, a critical review of the literature is presented, which illustrates the socio-historical constructions of female orgasm in relation to three distinct temporal periods; classical, modern and contemporary. The discursive constructions of orgasm within these epochs are considered in relation to research and treatment development.

The thesis then presents the analysis which used semi-structured interviews to explore how six clinical psychologists and two psychosexual therapists make sense of the work they do with women experiencing difficulty with orgasm. The transcripts were analysed using a FDA.

A critical realist social constructionist epistemological position was adopted in this research to facilitate the exploration of the constructed nature of orgasm, both at the local level of the text and the wider institutional level, to explore contextual and social factors and their implications for subjectivity.

The analysis identified that clinicians construct their understanding of therapy with women experiencing difficulty with orgasm in three main ways. They constructed their practice in terms of pursuing expert knowledge to secure professional power. They constructed the women with whom they work as 'problematic' yet 'untreatable' in the context of dominant biomedical discourses. Finally, they constructed the broader service context as regulating the ways in which they are able to conceptualise and 'treat' this presentation, thus perpetuating a pathologising construction.

This thesis recommends that clinicians should focus on interventions that promote a strength-based and systemic approach, which adopt a preventative stance towards addressing this phenomenon, involving social action and community development. Finally, supervision and reflective practice is

recommended to increase awareness of the impact of social discourses on the subjectivity of the women who present for 'treatment'.

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CHAPTER ONE: INTRODUCTION

The historical conceptualisation of the female orgasm has been multifarious. Scholars, academics and philosophers, throughout history, have debated the functionality and implications of orgasm, and indeed its absence, on women. Many theories of orgasmic functionality can be located within a biomedical framework, which privileges evolutionary explanations (Engel, 1977). Biomedical constructions of orgasm have positioned the absence of orgasm in women as problematic (American Psychiatric Association (APA), 2013). Critical voices, informed by postmodern and feminist theories have, however, argued that this conceptualisation of orgasm induces pathology due to its reductionist approach, which locates the problem in the individual women at the expense of considering contextual factors (Tiefer, 1996). The assumptions underpinning the theories attending to orgasm, and its absence, have implications for the types of treatments offered to women. Present day treatments of orgasm difficulties in women are not considered to be as effective as for other mental health difficulties (Weiderman, 1998). The problem this research hopes to address, therefore, relates to how the absence of orgasm in women has become constructed as pathological, yet untreatable, in order to explore the implications for subjectivity and practice of these constructions.

Foucault argues for the necessity in taking an historical perspective when exploring a particular problem (Kendall & Wickham, 1999). Therefore, in order to understand how orgasm has come to be positioned as pathological, yet untreatable, one must first understand, historically, how orgasm came to be formed. As such, this research will assume a Foucauldian informed approach to analysing the conditions of possibility in which orgasm is presently conceptualised. This research is concerned with exploring how orgasm is talked about by clinicians working with women who self-identify as having difficulty experiencing orgasm. It is interested in how clinicians negotiate the various constructions of orgasmic experience, and their work, with their clients. It will consider the different theoretical conceptualisations of orgasm and, most

importantly, how these different constructions of orgasm affect subjectivity for both clinicians and the women they 'treat'.

Subjectification is a term which means, both to produce subjectivity, and the constitution of a subject (Henriques et al., 1998). The process involves the construction of socio-historical and culturally located identities (Henriques et al., 1998). The subject can be considered to be continually co-constructed in social action (Burr, 2004)¹. In summary, this research will consider the constructions of orgasm in relation to processes of subjectification. This will be achieved through exploring how eight clinicians, working with women experiencing difficulty with orgasm, constructed their understanding of therapy through semi-structured interviews with myself; a trainee clinical psychologist.

This thesis will be presented throughout four chapters. The first will present an historical analysis and critical review of the literature, research and treatment available in relation to the socio-historical construction of orgasm. It will explore the discursive shifts relating to the constitution of orgasm and resulting implications for subjectivity. Chapter two will explain the methodological approach taken in this research, while chapter three will present the analysis from the eight interviews with clinicians. Finally, chapter four will present a critical review of the research, a personal reflexive account of the process, as well as a discussion of the implications for clinical psychology and ongoing research.

1.1. Language

This thesis is written in the first person for two important reasons. Firstly, to improve the audience's experience when reading the research, and secondly, to demonstrate the constructed nature of this research from which I, as the researcher, am inseparable. This research does not attempt to make objective claims about what there is to know about this topic, but should be understood as one of many ways to conceptualise the aforementioned 'problem'.

¹ See methodology section 2.5. for further explanation of subjectification

Throughout the research I shall be avoiding the use of pathological terms, such as 'anorgasmia', although it is commonly used to describe women's experience if they have difficulty with orgasm. I shall also attempt to avoid unthoughtful use of diagnostic labels as a short-hand for individual experiences. My rationale for this is due to the effect that language is thought to have on shaping our social world and identity and, thus, our lived experience (Burr, 2003; Willig, 2008).

1.2. Literature Search

For the purposes of this research, I utilised a number of approaches to literature collection. Firstly, I completed a systematic search using PsychINFO and Science Direct databases. The search terms were refined through 'title' and 'subjects' within PsychINFO and 'abstract, title, keywords' in Science Direct. The chosen terms which constituted the advanced searches were aligned to my research questions and were as follows:

- Orgasm* AND discipl*
- Orgasm* AND profession*
- Orgasm* AND clinician
- Orgasm* AND psycholog*
- Orgasm* AND construct*
- Orgasm* AND clinic*
- Orgasm* AND therap*
- Orgasm* AND prac*
- Therap* AND construct*

Further refinements were made so that only journals, published in English, were included. Following an initial screening of the title, and abstracts of the generated literature, I selected the research which appeared to be appropriate to this thesis. I then performed a citation search from useful articles which allowed me to find relevant leads and follow up references that had informed other interesting research. Finally, I performed a more targeted approach,

looking at research and academics whom, I knew, had been influential in this field.

1.3. Philosophical Delineation

The historical analysis will seek to elucidate the discursive shifts that have been implicated in the construction of orgasm. A specific emphasis will be given to the classical, modern and contemporary philosophical periods in Western civilisation. The rationale for selecting these distinct historical periods is to demonstrate how the constructed nature of sexuality has differed temporally.

The classical period of philosophy can be located in ancient Greece and Rome around the 7th Century BC, to 5th Century AD. The focus on this period, albeit brief, will serve to illustrate how the historical constructions of sexuality can differ, and how divergent they appear compared to our familiar, contemporary constructions. Foucault himself was also interested in this historical period in relation to his work on ethics, and wrote about it in the use of pleasure (1984).

Philosophical modernism can be located in Western culture and corresponds, roughly, to the late 19th and early 20th Century. The modern period is often associated with the age of reason which asserted that 'mankind' should be freed from superstition and the powers of the state in order to achieve progress (Mastin, 2008). It can be characterised as a period in which the reliance on biblical truth was replaced by reason, rationality and science. This period saw the inception of empiricism, an individualist theory of knowledge. Empiricism is one of many approaches to the gathering of knowledge. It places importance on evidence and asserts knowledge acquisition is only possible via sensory experience, i.e. observation (Psillos & Curd, 2010).

The contemporary period is considered to be a Western philosophical movement, beginning in the latter part of the 20th Century. This philosophical period can, rather crudely, be characterised by its analytic-continental divide. Contemporary analytic philosophy was largely considered to have flourished in English speaking countries; UK, Australia, Canada and the USA, as well as Scandinavia. Some of the relevant theories underpinning this period include

reductionism, empiricism and logico-positivism. Contemporary continental philosophy is mostly associated with Latin Europe. This philosophical approach rejects science as key to understanding phenomenon and places importance on factors, such as context, time and space in understanding subjective experience (Critchley, 2001). Poststructuralism and critical theory are philosophical schools or movements affiliated to this philosophical period (Critchley, 2001), and have been hugely influential in shaping how phenomena are understood and experienced. As such, it is necessary to elucidate these theories further, in order to explore their implications for the research and treatment of sexual difficulty historically. This shall be elaborated upon in section 1.6.2.

A discussion relating the historical periods, movements and doctrines of philosophy will now be presented, which will seek to scaffold the readers' knowledge through an historical exploration female orgasm. Particular attention will be paid to the construction of orgasm, the construction of its absence as problematic through research and the possible implication of these factors on treatment within a psychosexual context.

1.4. Classical Antiquity

The ancient civilisations of the Greeks and Romans constructed sexuality and sexual acts through alternative discourses to those recognisable in the present day. While it is not possible to provide a comprehensive overview of Greek and Roman history in this chapter, a brief summary in relation to sexuality shall be presented. For the Greeks and Romans, sexuality was not primarily conceived through sexual orientation, but through social status. The role that each participant in the sexual act occupied was conceptualised as active-penetrator or passive-penetrated (Oxford Classical Dictionary, 2005). According to Foucault (1984), the passive recipient of sex was not expected to derive any pleasure from the encounter. Whilst it was often the case that men took up the active role and women assumed the passive, homosexual relations were common. As such active/passive polarisation paralleled dominant/submissive social roles; the former associated with higher social status, masculinity and maturity, whilst the latter associated with lower social status, femininity and

youth (Oxford Classical Dictionary, 2005). A penile penetration discourse can be understood to have been dominant during this historical period. The subject positions available within this discourse could, therefore, be constructed as powerful or weak.

1.5. The Modern Period

Laqueur (2009) noted that the word 'orgasm' entered our vocabulary in the late 19th Century and speculated this was a significant historical moment. He does concede, however, that the phenomenon existed prior to its lexical inception. Nevertheless, the conceptualisation of female orgasm has shifted over time. Foucault (1978) considered sexuality to be a construct that has grown out of certain types of discourse. He noted that sexuality became a salient question in the late 18th Century (1978). During this period a number of 'technologies' were borne to regulate the individual's sexuality, or sexual essence. An example of such a technology can be seen in the confessional, whereby individuals were required to divulge sexual behaviour and desire to a priest. Sex, therefore, became an object of knowledge. This technology occurred within a religious context, then psychological (through psychoanalysis) and finally, political (through population control). The proliferation of discourses at this time ensured that sexuality continued to be an object of concern and knowledge, as the need arose to detect violations from the 'norm'. As such, those who deviated from socially sanctioned experiences were categorised; a process which saw the construction of 'the homosexual', for example.

Foucault (1978) asserted that these discursive shifts occurred in parallel with the scientific revolution, as scientific discourse merged with confessions, resulting in codified scientific data and a discourse on sex. Through his historical exploration of sexuality, Foucault (1978) identified that sexuality became relevant for political agenda in the 18th Century, as issues concerning population, life expectancy and birth and death rates became salient. He termed this concept a 'deployment of alliance' (p.106); a system whereby reproduction was tied to economy and the role it played in the distribution of wealth. It was gradually superimposed by a 'deployment of sexuality' (p.106),

which, by contrast, linked the body to the economy through what it consumed and produced, and which was primarily concerned with sensations of the body. Historically, a 'deployment of alliance' was the dominant discourse which, arguably, resulted in the inconsequentiality of female orgasms. This can be identified as it was in direct contrast to a system which placed importance on the quality of bodily pleasures. However, gradually a 'deployment of sexuality' formed through the requirement of previously unanswerable questions regarding such issues as "perverse or impotent husbands, the frigid wife and precocious child" (1978, p.111). Through the concerns relating to family difficulties and sexuality, Foucault (1978) identified that societies developed an increased tolerance for sexuality and the pursuit of pleasure. It was, therefore, throughout the 19th Century, that sexuality and sexual desire became an object of scientific interest.

Prior to the Victorian era, female sexual pleasure was linked to procreation and regarded as unproblematic (Laqueur, 2009). During the Victorian era, however, a lack of orgasm in women was considered to be linked to disease. Its absence was considered a precursor to the historic classification of 'hysteria', as women were unable to reduce stress via intercourse or sexual release. This occurred in a context whereby women's sexuality was suppressed (Archer & Lloyd, 1985). This discursive shift can be used to illuminate the changing conceptualisations of women's orgasm during this time. Post Victorian era, in the early 20th Century, the psychoanalyst, Sigmund Freud published theories which were influential in the early modernist period. Freud's interest in sexuality led him to publish his Three Essays on Sexuality (1905). In them, he proposed that a difference existed between clitoral and vaginal orgasm, with the experience of vaginal orgasm indicating the maturation from girl to woman. During this time, women who 'chose' to experience clitoral orgasm were considered to be denying their maternal and biological obligations. As such, heteronormativity was positioned as 'normal', 'natural' and sanctioned expressions of sexuality, with penetrative intercourse privileged. This theory paved the way for orgasm to be considered a process of psychogenesis² (Laqueur, 2009) and established sexology³ as a modern science (Tiefer, 1995).

² the development of a disorder categorised by psychological rather than physiological factors

³ the study of human sexual life, as a modern science

This process is relevant to the argument presented herein, as it demonstrates some of the conditions of possibility that have led to the present day constructions and treatments of orgasm. This point shall be elucidated in the next section.

1.5.1. Research during the Modern Period

The dominance of psychodynamic theory is still evident in present day approaches to the research of orgasm. For example, in an illustrative study, Brody (2006) used an empirical approach to demonstrate the primacy of penile-vaginal intercourse (PVI). This research draws partly upon psychodynamic theory to assert that vaginal orgasm, achieved through PVI, is associated with better physiological and psychological function. It also postulates that vaginal orgasm is accessible to women, and that sex therapists should incorporate scientific evidence in supporting this fact when working with 'affected' women. There are at least two interconnected discourses being drawn upon in this research. Firstly, an empiricist discourse, which privileges scientific research and its resulting evidence and secondly, a heteronormative discourse, which privileges PVI and vaginal orgasm, as per Freudian theory. Brody asserts that professionals working with women must draw upon scientific evidence to support their treatment, thus highlighting the possibility and benefit of vaginal orgasm. Therapeutic resistance to this guidance is presented as a "wilful imposition of a destructive ideology [that] might have had its roots in the belief that it was some sort of kindness to render persons with limited sexual function less aware of their shortcomings" (2006, p.402). The application of these discourses has implications for the subjectivity of clinicians who do not subscribe to the same constructions of orgasm. If they do not adhere to the scientific evidence when treating women unable to orgasm vaginally, then their actions may be constructed as misguided, or harmful, due to not maximising their clients' psychological and physiological functioning. Yet, at the same time, their actions are also constructing the clients' psychological and physiological functioning.

1.5.2. Treatment during the Modern Period

The history of sex therapy is relatively brief. A psychoanalytic framework was considered to be the dominant model of treatment for sexual difficulty from the

start of the 20th Century, until as late as the 1960's (Weinstein & Rosen, 1988). Treatment under this model consisted of long term, indirect, individual psychotherapy to attend to intrapsychic conflicts manifesting themselves as sexual difficulty. This treatment approach was gradually replaced with behaviourism following the seminal works of Masters and Johnson in the 1960's (Kaplan, 1979). They published a report documenting a new therapeutic approach which had a significant clinical impact on the way clinicians approached treatment for sexual difficulties. As a result, Masters and Johnson's approach to the treatment of sexual difficulties became more common throughout the 1970's. The dominance of this behavioural approach constituted the new discipline of 'sex therapy' and usurped psychoanalytic approaches, due to its brief, problem-focused and directive nature. However, the assumptions of behaviourism are deeply rooted in a realist approach to knowledge generation and, as such, offer a restrictive and individualistic understanding on the cause of orgasm absence.

The early 20th Century saw psychiatry become increasingly professionalised and medicalised (Angel, 2010). In America it also became significantly psychodynamic in orientation. Women who preferred clitoral stimulation were constructed as behaving similarly to men and denying their maternal obligation. Heteronormativity and procreation discourses elucidated norms for female sexual experience, such as the preference of vaginal orgasm during intercourse. This, arguably, created sanctioned ways of experiencing sexual pleasure that minimised female satisfaction by privileging male experience. The standardisation of psychiatry and construction of female sexual problems as medical disorders became manifest in the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published in 1952. This edition of the DSM combined both biological understandings of sexuality with Freudian, psychoanalytic, theory. This process demonstrates the constructed nature of sexuality according to the dominant understandings of the time. However, biomedicine, had only just begun to assert its influence due to scientific developments and cultural shifts. This shall be further explored in the next section.

1.6. The Contemporary Period

In terms of cultural shifts, 1960 saw the release of the first oral contraceptive, 'Enovid', to the mass market in the United States of America following approval from the Food and Drug Administration (Thompson, 2014). This development in women's contraception was culturally significant as it marked the separation of sex and desire from reproduction and, thus, the orgasm (Laqueur, 2009). Gordon (1976) saw the advent of birth control as a social movement that created a significant material change for women. Indeed, Laqueur (2009) quoted the feminist Betty Dodson who asserted that "everything beyond masturbatory orgasm is simply how we choose to socialize our sex life" (1974, p.18). The separation of procreation from sexual intercourse transformed women's relationship with sex and its functionality, thereby placing a greater emphasis on female sexual satisfaction, and orgasm. As such, women's relationship to their sense of entitlement about sexual satisfaction became more explicit.

Throughout the 20th Century, psychiatry evolved from assuming a dominant psychoanalytic position towards behaviourism in the latter half of the century, across all fields. This change can be evidenced through the various editions of the DSM (APA, 1952). Prior to the third edition of the DSM, female sexual problems were formulated principally from a psychodynamic perspective. The categorical shift in psychiatry's theoretical orientation occurred around the late 1970's, marked by the publication of the DSM III, as psychoanalysis was superseded by biological psychiatry. This shift marked an attempt to move towards scientific, rigorous and reliable diagnostic criteria that claimed to be neutral to any one particular theoretical approach (Angel, 2010).

Within the DSM III, a separate chapter was dedicated to 'Psychosexual Disorders' (APA, 1980) which was further amended in 1987 for the revised edition (DSM III-R) to 'Sexual Dysfunctions'. The classification 'inhibited female orgasm' was introduced, which was categorised by "a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase" (APA, 1987, p505.) More recently, the DSM has been through three additional revisions. The DSM IV (APA, 1994) saw the classification change to 'female

orgasmic disorder' (FOD). This has remained consistent in DSM V (DSM, 2013). The diagnosis was categorised by "a marked delay in, marked infrequency of, or absence of orgasm [and/or] markedly reduced intensity of orgasmic sensations" (APA, 2013, p.430). The DSM III-R constructed "orgasmic capacity in females [as something which] increases with age" (APA, 1987, p.505) and, therefore, younger women are more likely to receive a diagnosis of 'inhibited female orgasm'. An interesting parallel can be drawn here between psychodynamic ideas about the correct way to orgasm, which privileges vaginal orgasm. The diagnostic criteria in the DSM III positioned orgasm as dysfunctional if it did not occur after "normal excitement phase" (APA, 1987, p.506). This so called 'normal excitement phase' was informed by the research of Masters and Johnson (1966) which presented a linear, stage-based, account of human sexuality, from 'arousal' to 'resolution'.

Whilst the DSM V did not amend the label attached to the experience of being unable to orgasm, they did insert an exclusion to diagnosis that stated women "experiencing orgasm through clitoral stimulation but not during intercourse [do] not meet the criteria for a clinical diagnosis of female orgasmic disorder" (APA, 2013, p. 430). This statement could be understood as marking a discursive shift from the psychoanalytic assertions privileging vaginal orgasms and penile-vaginal intercourse. It could also be considered as a form of resistance to the heteronormative discourses prevalent in the previous editions of the DSM. Nevertheless, the DSM's inclusion of a heterogeneous and universal classification of orgasm difficulty has been understood by some as medicalisation; an argument which shall be elucidated in section 1.6.2.2.

1.6.1. Empiricist Informed Research during the Contemporary Period

Research during the mid to late 20th Century can be categorised, somewhat crudely, within the analytic-continental divide, that is, as operating within a realist or social constructionist approach to knowledge seeking. Within the realist tradition of psychological research, the biomedical model assumed dominance. This biomedical model has been positioned as the dominant model of disease within Western cultures (Engel, 1977). Devised by medical scientists, it is underpinned by the assumption that illness is something which is located inside one's body, and which fails to attend to any contextual factors that may also be having an effect. This approach to knowledge privileges

biological understandings of deviations from the norm of measurable scientific variables. The framework demonstrates a limited interest in the effects of psychological, social and behavioural influences and, thus, privileges the principles of individualism. The biomedical model looks to biochemical and neuropsychological processes to explain behavioural aberrations (Engel, 1977). As such, this model assumes both a reductionist position (a philosophical perspective located within an analytic philosophical movement, in which medical phenomena are understood through research on their constituent biological parts (Tiefer, 1996)), and mind-body dualism (the Cartesian principle, whereby the mental and somatic are separate). Engel (1977) asserts that this approach to medical knowledge has become a “cultural imperative” with doctors socialised by this model before even embarking upon their professional training. He continues that a biomedical approach has become dogma; that the model’s parameters fail to adapt, or face revision, in light of discrepant data. Consequently, dogmatic biomedicine embraces an exclusionist approach to knowledge in which data unexplainable by the model are excluded. This, arguably, perpetuates undesirable scientific and social consequences resulting from its dominance.

Foucault shared his thoughts about how scientific discourses, and the construction of normative practices, can be considered a technology of power. He asserted that the way society conceives of sexuality is a result of power’s productive capacity through these technologies (Foucault, 1978). Thus, medicine can be considered a technology, due to its role in developing a ‘norm’, and dictating sanctioned sexual experiences. Foucault (1978) identified that the focus of medicine shifted from occupying a position in which it was concerned with individual health, to one in which it dictated the physical and moral standards of society. Medicine’s concern with standardisation and ‘truth’ can be said to have facilitated this shift. It sought to enforce a standard which, at the same time, it was trying to establish by comparing and measuring individual difference. The result being the identification of a ‘norm’ and assertion of this ‘truth’ as a sanctioned action.

Understandings of orgasm were developed throughout the 20th Century, with prominent research being conducted by Masters and Johnson (1966) and The Kinsey Reports, (Kinsey, Pomeroy, Martin & Gerhards, 1953). Masters and

Johnson (1966) developed the Human Sexual Response Cycle, a model which they attributed to biological and evolutionary origins, and one which epitomised the medicalised sexuality of universal human capacities, tendencies, and functions (Tiefer, 1996). Their research examined the physiology and anatomy of the human body during sexual arousal. The study was conducted in a laboratory setting and identified, through direct observation of participants' sexual stimulation, four stages of the human sexual response cycle: the excitement, plateau, orgasmic, and resolution phase. These phases described human sexual experience from the initial arousal state, through to the achievement of orgasm, before returning to the original unaroused state. Kinsey (1953) interviewed approximately 6000 women to explore the varieties of sexual activities and behaviours. The main findings of this research contributed towards understandings about rates of homosexuality and discredited Freud's theories of orgasm to maintain that clitoral orgasm was important for women's sexual satisfaction. Both Kinsey, and Masters and Johnson, used orgasm as a measure of sexual satisfaction (Lavie & Joffee, 2009). Their research saw a shift from the favoured vaginal orgasm to asserting that all orgasms are identical. This has been considered influential in the development, and classification, of female sexual difficulties within a biomedical model, resulting in diagnosable conditions including 'female orgasmic disorder' (Althof et al., 2005). Contemporary studies corroborate the notion that the clitoris is the primary source of sensory input for triggering orgasm and argue that clitoral and vaginal orgasm are biologically indistinguishable (Mah & Binik, 2001).

The functionality of orgasm is something many scientists still explore (Wheatley & Puts, 2015). Some of the dominant theories of orgasm functionality have suggested that longer penises are more likely to invoke vaginal orgasms generated through penis-vagina intercourse (PVI) (Costa, Miller & Brody, 2012). This type of research is positioned within an evolutionary context which views vaginal orgasm as part of mate selection. Costa et al. (2012) assert that the relationship between PVI orgasm and penis size is likely to affect fertilization, as the male is selected for fertilization efficiency and sperm competition ability. As such, they argue that penis size is important to women, an assertion which is consistent with evolutionary hypotheses concerning the mate choice. Puts,

Dawood and Welling (2012) support this theory of mate selection, although offer an alternative; the byproduct hypothesis. This theory states that female orgasm exists as an evolutionary adaptation, because they share some early ontogeny with men. However, their research reveals that the mate choice hypothesis reveals most support among the literature. Meston et al. (2004) present a number of alternative biologically informed hypotheses about the functionality of female orgasm, which include: the reward of intense pleasure for acceptance of the danger of coitus with its possibility of pregnancy (and of possible death in childbirth), to end coitus, for resolving pelvic vasocongestion/arousal and for resolving vaginal tenting (the process allowing the cervix to enter the seminal pool). This approach to research not only dominates the literature, but also underpins some of the most commonly used treatments for women experiencing difficulty with orgasm. Those particular treatments will be attended to in section 1.6.3.

1.6.2. Social Constructionist Informed Research during the Contemporary Period

A social constructionist approach to knowledge dominates the continental movement of the contemporary period. As previously presented, social constructionism is interested in the processes of knowledge construction, and places importance on contextual factors influencing subjective experience (Harper, 2011). It rejects the biomedical claim to knowledge, as reductive, individualist and pathologising.

Women's orgasms continue to be subject to scientific scrutiny in the Western world. As such, the evolutionary function of orgasm remains disputed and there still exists controversial debates concerning clitoral versus vaginal orgasm (Frith, 2013). Two discursive constructions of orgasm have been identified through previously conducted research by Gavey, McPhillips and Braun (1999), and Potts (2000) respectively: the coital imperative and the orgasm imperative. The coital imperative (originally discussed by Jackson (1984)) relates to the indispensability of penetration during sex, and the orgasm imperative asserts that orgasm is a peak sexual experience. Frith (2013) argues that research has demonstrated that these constructions unequally position women in relation to men whilst reinforcing heteronormativity. The orgasm imperative (Potts, 2000) dictates that orgasm is the target of heteronormative sex, the peak of sexual

satisfaction and intimacy. Within this imperative, orgasm is constructed as something to be experienced with an other. The implication for these constructions and discourses is that failure to adhere to the normalised expectation is positioned as 'pathological', and creates the subject position of pathologised, or 'the anorgasmic women' (Potts, 2000). Gavey et al. (1999) assert that the coital imperative elucidates some of the reasons why penetrative sex is privileged. They identified through their research that penetration is a socially sanctioned expression of desire that is socially determined and normalised, despite its tacit biological explanation. This assertion is in contrast to the dominant biomedical constructions and can be considered an example of normalisation⁴.

Heterosexual ideals have been shown to promote the alignment of the two gender roles and continue to dominate male and female discourses, positioning female sexuality as passive, and male sexuality as active (Cacchioni, 2007; Gavey et al., 1999). This is reminiscent of Roman discourse, although somewhat reconfigured. In her book, 'Gender Talk', Speer asserts that discourse is often gendered and that it can "naturalize and perpetuate oppressive understandings of gender...as we present them as timeless and natural" (2005, p.7). She argues that the concept of heteronormativity simply reinforces the stereotyped assumptions of patriarchy that discourse creates through gendered language. As sex is a means by which we classify our world, splitting it into categories of male and female, once again, reinforces heteronormativity.

Lavie and Joffe (2009) examined the social context upon which these constructions are built and found that orgasm is symbolised as the goal of sex. Their research demonstrated the absence of orgasm is positioned as 'problematic', with those women unable to experience them positioned as 'dysfunctional'. According to Lavie and Joffe (2009), the implications of this construction for women who do not experience regular orgasm is that they become stigmatised and experience feelings of shame as a consequence. Nicolson and Burr (2003) illustrate the implications of a patriarchal discourse on the construction of women's sexuality in relation to men's sexuality. They argue

⁴ See section 2.6.3. for a detailed presentation of Foucault's concept of normalisation.

that dominant biomedical approaches in research perpetuate the construction of orgasm absence as problematic, as they does not challenge the effects of wider contextual factors and language on the subjectivity of those positioned as affected. They postulate that sexology literature and research is creating a “mythical standard against which women measure themselves [which] serves to continue to reinforce the importance of penetrative sex and the satisfaction of male sexual desire” (2003, p.1743). The consequences of failing to attend to discourse and cultural processes in the construction of orgasm as problematic may be responsible for rendering it untreatable, as there are no alternate subject positions created for women to take up.

1.6.2.1. Feminist Criticisms of the Biomedical Model of Sexuality

Hartley claims that the “biomedical model downplays the diverse relational, cultural and individual factors impacting sexual experience”, such as relationship dynamics, the effect of popular media, and socially sanctioned sexual expectations/experiences (2002, p.109). Tiefer (1996) has also publically written that a biomedical approach offers a limited perspective for conceptualising the difficulties people present with in relation to sexuality. She presents a number of reasons for this, which include: the reliance on norms, its focus on disease and not people, its Cartesian dualism underpinning and biological reduction principles. Tiefer, Hall and Tarvis (2002) continue that defining and measuring disorders relating to female sexuality is a complex task which requires the cohesion of biological and psychological factors. Moynihan (2003) recalls an interview with Tiefer in which she commented that “sex is like dancing...if you break an ankle while you’re dancing you go to a doctor. But your doctor doesn’t take a dance history and wouldn’t advise you whether your dancing is normal. The biomedical model is about defining what’s healthy and what’s sick – but sex isn’t like that.” (2003, p. 47).

The incredibly complex issue of whether female sexual dissatisfaction should be classified as a medical dysfunction is attended to through feminist perspectives, and also through a pharmaceutical, medicalised perspective (Lavie-Ajayi, 2005). The feminist perspective asserts that a biomedical framework potentially reduces female sexuality into discrete universal categories concerned primarily with physiological functioning (Tiefer et al., 2002). The reasons why this may be considered problematic through a feminist perspective is elucidated by

Marshall (2002), who asserts that the sexual satisfaction of women must be examined within context and cannot be approached with a simple question of mechanics. Indeed, the DSM's (APA, 2013) approach to sexual dissatisfaction as simply physiological creates difficulties as the 'one size fits all' approach to treatment is not always relevant considering the complexities of female sexuality (Tiefer et al., 2002), namely, orgasm.

The current dominant biomedical perspective has significant implications for women's sexual and mental health. Tiefer (1996) asserts that the biomedical model permeates and constructs both professionals and lay thinking in relation to sexuality. The main reason for biomedical dominance has been hypothesised by Fishman (2004), who argues that it relates to the social change our society is experiencing, creating a more accepting attitude towards biological solutions (Fishman, 2004). This biomedical perspective also reinforces our societal and cultural values of efficiency and supports an economic and medicalised agenda, this results in an inter-dependence upon profitable pharmaceuticals (Hartley, 2002).

1.6.2.2. The Medicalisation Debate

Medicalisation, occurring under the guise of biomedicine, influences the construction of sexuality through affecting theory, legislation and research (Tiefer, 1996). The mind-body dualism associated with the biomedical model facilitates the persistent separation of mind from body in order to identify the bodily components of disease. This supports their epistemological position in that there are universal truths to be known, as all bodies are homogeneous and, thus, unaffected by cultural or societal factors. Indeed the DSM V (APA, 2013) directs that all possibility of medical, physiological, or substance abuse conditions be eliminated prior to assessment of psychological difficulty. The medicalisation of sexuality is contingent upon the assumptions generated within Cartesian dualism, as it perpetuates 'normal' sexual function as a result of correct physiology which strengthens the rationale for ongoing, relativist, physiological research. The assumption of individualism within the biomedical model locates the perceived 'problem' within the person, and discounts any relational, contextual or socially relevant factors which may have impacted upon that person's experience. Academics, such as Boyle, have argued that the impact of focussing on the individual devoid of context operates as a "safety

strategy” to continue the dominance of the biomedical model. By obscuring the potential impact of context, personal experience is simplified, sanitised and neutralised. The effect of this encourages descriptive and simplistic research, for example, symptom rating etc. This approach to research, Boyle argues, limits the production of “detailed analytical theorizing about the nature of presentations and their importance” (2011, p.34). This in turn perpetuates the underpinning assumptions of the biomedical model that symptoms are directly related to an internal pathology, thus, reinforcing the medical framework within which biomedicine rests. To acknowledge the saliency of life experience and social context would be considered a direct threat to psychiatry’s authority and expert position. This process is evident through identifying the dominant constructions of orgasm currently privileged, which happen to be biomedically conceptualised as a physiological event that requires individualistic treatment.

The construction of an objective, universal body, as promoted by the biomedical model, perpetuates a belief that there is a sexualised body to ‘know’ and continues to feed the over-medicalisation of its difficulties. Foucault (1990) considered the use of expert knowledges to define behaviours which are normal, acceptable or deviant. Expert knowledges are unpinned by objective truths which serve to define norms; a set of socially accepted behaviours, deviations from which alert us to ‘dysfunctions’. In terms of orgasm, a sanctioned way in which to experience sexual satisfaction is constructed, and any deviations from which results in its problematisation.

1.6.2.3. Sexuo-pharmaceuticals

The focus of contemporary female orgasm research remains heavily funded by the pharmaceutical industry, with the focus firmly on biochemical solutions to orgasm difficulty (Moynihan, 2003). The development of Viagra, in 1998, contributed towards a new medicalised discourse of sex (Tiefer, 2006). Like the contraceptive pill of the 1960’s, Viagra became a cultural icon which continues to affect our cultural norms. The success of this drug arguably reinforced the penis as being central to sexual satisfaction, whilst supporting a heteronormative discourse (Cacchioni, 2007). Consequently, sexual satisfaction has become thought to be the result of correct and fully functioning physiology and has, thus, become medicalised (Tiefer, 2006). Although this process appears to be partly to do with advances in medicine the growing

influence of biomedical interventions for sexual difficulties appear to be motivated by unethical issues (Weiderman, 1998). That is, for example, pharmaceutical companies stand to profit from proliferation of biological interventions. As a result of social stigma associated with normalisation, Schover and Leiblum (1994) have argued that many people would rather be diagnosed with a medical condition than a psychological one, which facilitates the avoidance of assuming personal responsibility for ill health and increases the focus on biology.

The feminist approach argues that a physiological framework of 'sexual dysfunction' ignores the social environment and relationships of women, implying that any physical difficulties can be treated regardless of context. In order to treat women's sexual health, the somatic, emotional, intellectual and social aspects of women, require attention (The World Health Organisation, 1975). Tiefer et al. (2002) also stated that areas such as social environment, sexual inhibitions, fear and miscommunication can all attribute to sexual dissatisfaction by preventing the expression of satisfaction. They continued that there is not one correct format that is capable of addressing the varied aspects of women's sexual response and experience. This view is contrasted against the biomedical model's claims of treatment efficacy for 'female orgasmic disorder', which shall, thus, be expanded upon.

1.6.3. Psychological Treatments Informed by Biomedical Research

The history of the sex therapy discipline is relatively concise. The dominance of the analytic approach to treatment was gradually eroded during the 1970's due to the popularity of behavioural theory, partly inspired by the highly influential research of Masters and Johnson (Weinstein & Rosen, 1988). In contrast to psychoanalytic treatment, the new behavioural approaches assumed a brief, problem-focused, approach and utilised interventions, such as behavioural exercises prescribing non demand pleasuring of the other to minimise anxiety reactions. This approach was considered highly effective and is thought to have had a significant impact on the discipline of sex therapy (Weiderman, 1998). In the 1960's, sex therapy become more prominent. Around the same time women's relationship with sexual pleasure was thought to have changed, in part due to the availability of the contraceptive pill. The women accessing sex therapy during the 1960's were reported as primarily requiring education to

overcome their difficulty with orgasm. However, the proliferation of self-help articles in popular publications meant that sexual advice was forthcoming from the mass media. The educational and behavioural approaches of sex therapy gradually become less necessary (Weiderman, 1998).

Cognitive-behavioural therapy (CBT) was developed from the integration of cognitive and behavioural theory by Aaron Beck in the 1960's (Beck Institute for Cognitive Behavioural Therapy, 2016). The theory advocates that our cognitions, and how we perceive situations, influence our emotional and behavioural responses and the meaning we give to events in our lives (Hofmann & Reinecke, 2010). This treatment approach is currently privileged and dominates the field of sex therapy, despite the absence of clinical guidance for orgasm difficulty from either the National Institute for Clinical Excellence (NICE) or the British Association for Sexual Health and HIV (BASHH). There are many possible reasons for this, including the dominance of the biomedical framework within which it is located, and its ability to produce measurable outcome data in line with realist approach to knowledge generation. Within CBT, the focus is on identifying and challenging any unhelpful sexually relevant thoughts or attitudes, thus, increasing orgasm function and sexual satisfaction. Treatment might incorporate behavioural exercises to support these changes and include; sensate focus; directed masturbation and systematic desensitization. Kegel exercises, sex education and communication skills training are also considered an important component of CBT informed therapeutic work (Meston et al., 2004). The common element in these approaches to treatment is that they all assume an individual pathology and, as such, do not privilege the impact on wider contextual factors.

There is a large body of research which purports to adopt a biopsychosocial approach to the investigation of effective treatments in relation to orgasm difficulty. The assumptions generated from this research advocate a number of reasons for the manifestation of this difficulty in women. These include: fearing a loss of control during orgasm (Heiman & Grafton-Becker, 1989), having a lack of awareness of physiological feelings of arousal (Heiman & Grafton-Becker, 1989), endorsing negative attitudes towards sex (McCabe & Coburn, 1998). These assumptions correspond with the apparent appropriateness and dominance of a cognitive behavioural therapeutic (CBT) approach within sexual

health psychology. Laan, Rellini and Barnes (2013) completed a systematic review which endorsed CBT as the 'gold standard' treatment for women experiencing orgasm difficulty, although placed a particular emphasis on directed masturbation (DM) as the most efficacious technique. However, the research often cited to demonstrate the efficacy of DM was conducted in the 1970's (Heinrich, 1976). It may, therefore, be considered as outdated as it was conducted in a different socio-cultural age whereby different discursive effects had different implications for subjectivity than would be considered relevant in the present day. The other systematic review that Laan et al. (2013) drew upon in their assertion of CBT efficacy was by Heiman (2002). In this review, however, Heiman (2002) states that most of the studies reviewed had significant weaknesses. Much of the evidence pays only lip service to a cultural or social component, despite advocating a biopsychosocial approach, as can be evidenced in Laan et al. (2013) and McCabe et al. (2010).

These therapeutic approaches share the same aim, which is to support the women to achieve orgasm. They share a global belief that there is a correct way to experience sexual pleasure which can be located as operating within a realist approach to knowledge. The main differences between psychoanalytic and CBT approaches to treatment of orgasm difficulty in women relates to the impact of maladaptive past (psychoanalytic) or present (CBT) factors (Weiderman, 1998). Both approaches locate the difficulty within the individual and pay little attention to the role of context. In this way, we can understand these therapies as aligned to a pathologising agenda.

1.6.4. Psychological Treatments Informed by Social Constructionist Approaches

Social constructionist approaches, such as systemic and narrative therapy, focus on language and its constructive nature in experiencing the self. Burr proposes that social constructionism experiences a person as "multiple, fragmented and incoherent" (2003, p.141). By this she means that the effects of different discourses, coupled with the processes of social interaction, create a multiplicity of selves. As such, systemic therapy understands reality as socially and linguistically constructed. The narrative model of systemic therapy (White & Epston, 1990) draws upon poststructuralist ideas. Both Foucault's ideas of subjugated and dominant discourses, and Derrida's concept of deconstruction,

take centre stage. The narratives that one holds about the self are considered to be created at a societal level and can become dominant and 'problem-saturated'. The process of deconstruction is therefore salient in order to challenge the effect that dominant, and unhelpful discourses, (such as heteronormative and patriarchal) are having on a person's subjective experience of their self-concept (Boston, 2000). This approach is relevant to the treatment of orgasm difficulty because of its focus contextual factors and their impact on the construction of selfhood. Systemic therapies also challenge the effect of culturally sanctioned practices, such as the correct way to experience sexual pleasure, through deconstructing the dominant discourses at play, such as heteronormativity.

Within the NHS there is a growing awareness that postmodern systemic therapy facilitates the efficacy of therapy, due to its variety of techniques and stances (Boston, 2000). However, in line with fiscal pressures experienced by the commissioners of NHS services, and large treatment waiting lists, therapy is consistently expected to be time limited and standardised. The present requirement for evidence-based practice and outcome measures, in line with a biomedical, modernist approach to knowledge acquisition, positions social constructionist approaches at a disadvantage as they do not subscribe to the same epistemology perspective (Laugharne, 1999) and, therefore, evaluative framework.

1.7. Rationale

This literature review has considered briefly the historical construction of the 'orgasm', the problematisation of its absence and its apparent untreatable nature. A review of the various discursive shifts has been presented, which has been historically located primarily within the modern and contemporary philosophical periods. The contributions of psychoanalytic, biomedical and social constructionist theories have revealed the multifarious ways in which the research and treatment of orgasm is approached and, ultimately, the various and differing ways in which they construct the orgasmic experience.

However, there is a dearth of literature exploring clinicians' understandings and constructions of orgasm and the implications these constructions have on the treatment of women experiencing difficulty with orgasm. The literature that is available on orgasm can, somewhat crudely, be categorised as informed by biomedical or feminist assumptions. As such, orgasm is positioned as something which denotes an essential part of female sexual functioning, with the lack thereof indicating individual pathology; a construction criticised by many feminist academics. There exists limited research exploring how these dominant constructions impact psychological theory and resulting treatments. And, more specifically, the implications for subjectivity for the women who do not experience orgasm, and for whom the mainstream treatments are unsuccessful. Consequently, this thesis adopted a critical realist social constructionist perspective⁵ which considers the constructed nature of a phenomenon and the material realities of said phenomenon.

A Foucauldian Discourse Analysis (FDA)⁶ will enable this study to understand the construction of orgasm as pathological. It is expected that this relativist epistemological stance will facilitate an examination of the socio-cultural discursive practices that problematise certain practices. It is my opinion that the absence of orgasm is not inherently problematic, rather various discourses have constructed it as such. As such, a critical realist social constructionist approach can helpfully map the power structures and discursive practices to explore how the absence of the orgasmic phenomenon is constructed as problematic, yet untreatable. By focusing on the multiple constructions of orgasm within a clinician's particular social, professional and political context, we can explore how the constructions shape clinicians' practice, and the implications of these constructions for the women always already labelled as 'pathological'. This research, and the examination of how discourses can influence certain constructions, is essential in order to ensure that clinical psychology meaningfully supports women experiencing distress as a result of difficulty with orgasm.

⁵ See section 2.4.

⁶ See section 2.5.

1.8. Research Questions

This study began with a broad research question:

- How do clinicians construct their understanding of practice with women experiencing difficulty with orgasm⁷?

In addition, the following sub questions were developed in order to analyse the research data:

- What impact do the clinician's constructions have on the treatment and embodied experience of women experiencing difficulty with orgasm?
- What are the implications of these constructions for subjectivity and practice?
- How are wider socio-cultural contexts imbricated with this discursive formulation of sexuality?

The next chapter shall direct the reader through a detailed discussion of the methodology used to answer the above questions in relation to ethics, participants and recruitment, data collection, interviews stages of analysis and reflexivity.

⁷ This research question contains the assumption of distress in the women seeking psychological help. As the research demonstrates, many women do not value orgasm as the pinnacle of sexual experience and, therefore, do not experience associated distress.

CHAPTER TWO: METHODOLOGY

2.1. Introduction

This chapter aims to provide an outline of the epistemological position and methodological framework adopted throughout this research study. A rationale for the chosen position will be detailed, along with an exploration of the various paradigms available within psychological research. Information pertaining to the method used, including data collection and transcription, participant profile and recruitment information, and the analytic approach will be presented. This chapter will conclude by considering the appropriateness of a critical realist social constructionist epistemology, in the context of this research study, by adopting a reflexive stance in relation to the position of researcher.

2.2. Methodological Rationale

The aim of this research was to examine how clinicians construct their practice in relation to working with women experiencing difficulties related to orgasm. The research sought to explore the socio-historical construction of sexuality, how the constructions are made and rendered problematic, and the associated implications for women who may be seeking treatment within a therapeutic framework. A qualitative approach to research was adopted due to the study's exploratory nature and the questions asked therein. This area is one of many that has been explored through a realist epistemological lens. In order to contribute to an alternative evidence-base, this research study privileges a postmodernist view of knowledge; that its construction occurs through linguistic interaction, where the participants' discourse, its structures and effects are of interest. As such, a Foucauldian Discourse Analysis (FDA) was considered to be the most appropriate method of data analysis, due to its consideration of how social action generates power to create regimes of truth. A further rationale for this approach to analysis shall be presented herein.

2.3. Research Paradigm

In understanding the process by which a research study evolves, one must first consider the concept of epistemology, which includes the wider philosophical concepts of paradigm, ontology and methodology. A paradigm is a belief system that guides the questions we ask, and our approach to conducting research. Paradigms can be understood by their epistemology, ontology and methodology. Epistemology is the philosophy of knowledge, or “the study of the nature of knowledge and the methods of obtaining it” (Burr, 2003, p.202). In essence it is *how* we come to know something. Ontology is concerned with the study of being and existence, or “the attempt to discover the fundamental categories of what exists” (Burr, 2003, p.203). Ontology questions our external world, asking; what is reality and the nature of ‘being’? Methodology, according to Silverman (1993), defines how one might embark upon studying a particular phenomenon. “[It] refers to the choices we make...in planning and executing a research study” (1993, p.15).

When embarking upon a research project, Willig (2008) proposes that three questions should be asked to establish the methodology’s epistemological roots. These questions map directly onto the philosophical concepts of epistemology, ontology and methodology respectively, and the consideration of each answer enables research to be evaluated in a meaningful way. The three questions are as follows:

1. What kind of research does the methodology aim to produce?
2. What kinds of assumptions does the methodology make about the world?
3. How does the methodology conceptualise the role of the researcher in the research process?

(Willig, 2008, p.12-13)

These questions provide a framework for the discussion and evaluation of this study herein.

2.4. Epistemology

Willig (2012) provides a clear exposition of the epistemological debates in qualitative research. She broadly explicates three main paradigmatic positions; realism; phenomenology and social constructionism. In line with Willig (2012) and according to the research questions, the appropriate and more specific epistemological approach for this thesis has been selected as critical realist social constructionist.

2.4.1. Critical Realism

It has been argued that there is a strong realist tradition within scientific research. Rather than taking a realist position, which suggests that particular phenomena exist independently from the expert neutral knower (the researcher), this research shall adopt a critical realist position. That is, the assumption of a realist ontological stance, whereby there exists a material reality, can also share an awareness that specific attempts at knowledge generation are imperfect, and influenced by the categories we impose as a result of our context, such as gender, culture etc.

2.4.2. Social Constructionism

This research has adopted a weak social constructionist position which, as Burr (2003) has carefully explained, can be considered to be a theoretical orientation which offers a critical alternative to mainstream psychological approaches to knowledge. While Burr asserts that there is not one encompassing definition of social constructionism, a view to which I am aligned, she alludes to a number of key assumptions which 'social constructionist' approaches might have at their foundation. These are well known, however, they shall be listed herein for the reader:

- A critical stance towards taken-for-granted knowledge
- Historical and cultural specificity
- Knowledge is sustained by social processes
- Knowledge and social action go together

(Burr, 2003, p. 2-5)

2.5. Foucauldian Discourse Analysis (FDA)

In attempting to elucidate the 'Foucauldian' approach to discourse analysis, the term 'discourse', must first be explicated. According to Parker, a discourse is a "system of statements which constructs an object" (1992, p.5). Discourses categorise the social world and, in so doing, illuminate phenomena. This facilitates different ways of understanding the world, and being in the world, to be made available to individuals (Parker, 1992; Willig, 2003). Discourse can be considered a discipline in itself; providing a way to communicate systems of a particular body of knowledge, such as; medicine, psychiatry and science, and also exposing the formation of certain objects, strategies and concepts.

Foucault's conception of discourse differs from the Anglo-American tradition in which it is seen as a linguistic practice. He formulated that society produces and regulates discourse and that, in this way, knowledge becomes an exemplification of power. As such, FDA can be usefully applied to critical psychological research. The fundamental principle of FDA is to ensure the historicity of the objects interrogated, regardless of the methods employed (Arribas-Ayllon & Walkerdine, 2008). Whilst there is widespread agreement that no formalised approach to FDA exists, there is consensus about what the broad dimensions of 'discursive practices' include (Arribas-Ayllon & Walkerdine, 2008). These three dimensions to a 'Foucauldian' informed discursive approach include: Consideration of the mechanisms of power and its operationalisation, an historical enquiry known as a 'genealogy' and, finally, an analysis of the material/signifying practices in which subjects are constituted, known as subjectification. This section shall aim to deconstruct these dimensions by using them as a means to further explain Foucault's approach to methodology.

A Foucauldian informed discourse analysis predicates a specific approach to research. In so doing, one might seek to understand the conditions of possibility that allowed the emergence of 'discourse' as a concept. We might ask ourselves how it has become possible to speak of 'discourse' and how contemporary psychology has allowed the application of Foucauldian discourse

analysis. Arribas-Ayllon and Walkerdine (2008) provide a comprehensive account of specific historical and cultural conditions out of which a Foucauldian conception of discourse emerged. Their analysis focused on the intellectual debates between humanism and Marxism in 20th Century France. Ultimately, Foucault sought to understand the concept of power in a more flexible way than had been conceptualised by previous ideologies. His vision was of a model of power that operated locally and in line with specific historical conditions.

Foucault asserted that power does not function to repress, exclude or censor the individual, but as a producer of reality through signification; the relationship between the signifier (idea) and the signified (action) (Saussure, 1983): “[power] produces domains of objects and rituals of truth” (Foucault, 1977, p.194).

Foucault continued that forms of subjectivity are constituted by material/signifying practices. According to Arribas-Ayllon and Walkerdine (2008) this understanding enabled Foucault to identify discourses related to diverse social groups including; medical patients, homosexuals and the insane, thereby linking them to the specific practices in which they were located by the idea/action nexus. This work led to the identification of links between the construction of subjectivity and institutional practices.

Foucault’s conceptualisation of knowledge as ‘discourse’ revealed psychology as holding an active role in constructing the social domain. According to his theory of knowledge and power Foucault reasoned that power acts both as an oppressive and productive force (Gordon, 1980). Its productive element creates the conditions of our social world, privileging certain discourses over others which lead to the production of knowledge, subjects and institutions (Jørgensen & Phillips, 2002). Gordon cited Foucault who asserted that “Individuals are the vehicles of power, not its points of application” (1980, p.98). This new critique was adopted by Britain as ‘social constructionism’, a theory which juxtaposes the Marxist view of knowledge and power. The social constructionist approach was able to move away from the society-individual dualism proposed by Marxism and acknowledge that psychology is not in pursuit of an objective, discoverable, truth. Rather, it asked different questions about the conditions of possibility for psychological knowledge. Whilst detailed consideration of genealogical concerns are not possible within the remit of this study, a skilful

explanation can be found in Arribas-Ayllon and Walkerdine's (2008) chapter on 'Foucauldian Discourse Analysis'.

As a result of these post-structural shifts, the 'individual' within psychology moved from one whose truths were discoverable through repeated scientific measurement by various apparatus and techniques and whom could be considered a rational being, to one whom was, in fact, constituted by the very process that saw its inception, for example; racism, intellectual disability, childhood sexuality. Subjectivity has become a way in which to demonstrate the historically contingent phenomenon of the individual, as an invention. Foucauldian informed analysis explores just how subjectivity, or the invention of the individual, the subject, can be understood as an object of 'technologies of the self'⁸. Subjects can be said to form the conditions for knowledge as they are produced through discourse, and it is through the produced bodies that the discourses act. It can also be asserted that the actions of a subject occur in relation to that subject's position along the discursive/non-discursive spectrum of knowledge. Foucault identified the subject, not as a producer, but as a product. He saw the constitution of the subject as fundamental to the productivity of power (Kendall & Wickham, 1999). In this way, the subject position, which is actually part of the interdependent triad of power, knowledge and the subject, has implications for individuals' action.

Based on the discussion so far, we can conclude that FDA offers a way to understand the positioning of subjects in relation to power and knowledge. The subject is considered to uphold a position that is maintained in relation to specific forces. The positions are various and often multiple; the mother, the sister, the worker. The subject positions are created as a result of force/relations interaction and, consequently, are inconsistent and conflicting. It must be highlighted that it is simplistic to assert that discourses determine subjects. Power itself does not have predictable, nor established, effects and, as such, there is always the possibility of a subject choosing to act in a non-

⁸ 'Technologies of the self' describe the process of construction of selfhood through the workings of psychological and other formal knowledge groupings, or sciences (Kendall & Wickham, 1999, p.53). Systematic discourses can be said to construct these knowledge groupings, such as, science, or psychology, which in turn produce selfhood. In this way discourses are productive of and constitutive of knowledge, and can, therefore, be understood as a technique of power (Kendall & Wickham, 1999).

prescribed way. “Where there is power, there is resistance” (Foucault, 1978, p.95).

2.6. Method and Practice

2.6.1. A Tool Box for Analysis

Foucault's interest in how forms of subjectivity are constituted by material/signifying practices led him to relate discourse to social groupings such as homosexuals, prisoners and the insane. Subsequent investigations into the effects of discourse revealed “heterogeneous links between institutional practices and the construction of subjectivity” (Arribas-Ayllon & Walkerdine, 2008, p.6). This identified interaction between theory and practice enabled Foucault to develop a number of conceptual tools with which to explore social change. Understanding the subject as constructed through mechanisms of social practice became an interactive, open-ended, process (Arribas-Ayllon & Walkerdine, 2008). Foucault proposed that his ideas could act as a toolkit with which to explore the effects of discourse on social change. “I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area” (Foucault, 1994, cited in O'Farrell, 2005, p.50). Foucault's aim was to produce books of experience; that the experience of reading his work might potentially change the reader. He wanted his legacy to be transformative and to promote independent thinking.

The next sections will elucidate the Foucauldian concepts of disciplinary power, normalisation and biopower, in order to orient the reader to some of the ‘tools’ which shall be drawn upon in the process of analysis. These forms of governmentality can be useful in understanding the processes by which female orgasm has come to be constructed as ‘pathological’ and ‘problematic’, and the associated implications for subjectivity.

2.6.2. Disciplinary Power

Foucault focused his genealogical study in ‘Discipline and Punish’ (1977) on a new type of power; disciplinary power. This new type of power was based upon Jeremy Bentham's panopticon; an ideal prison in which an inmate is rendered

permanently visible; they can be seen at all times, but cannot see. Order is thus guaranteed as the individual is induced into a self-disciplining state. A central guard tower is surrounded by cells in which inmates are unable to distinguish the direction of the guard's gaze. The trap of visibility assures self-disciplining behaviour (Foucault, 1977). Rather than being enforced through violent conduct, disciplinary power is operated through the internalisation of a permanent surveillance; located within the individual, as opposed to the monarch or sovereign. Elements of the mythical panopticon can be seen in present day, through our schools, hospitals and airports. Our society utilises anonymous surveillance routinely through GPS, CCTV, social media and contactless payments. For Foucault, the relationship between knowledge and power is always paramount and the panopticon demonstrates this beautifully. When individuals' behaviour can be continuously observed, it can also be thoroughly assessed. The amassed knowledge facilitates the effect of power. As a consequence society's behaviours, experiences and desires can be shaped; thus creating a norm. Deviations from this norm can be punished, or rewarded. The interdependence between techniques of power, forms of knowledge and their subjects, as evidenced by the panopticon, is a key principle upon which contemporary power operates.

2.6.3. Normalisation

Foucault asserted that the process of subjectification, the construction of the socially recognised individual subject, was only possible within society's knowledge/power networks. He did not consider identity to be predetermined, but constituted through practices of power and knowledge. Power relations are composed of the subjects themselves, not created in the in-between. Not all knowledge/power relations are equivalent and Foucault recognised that therein exists a hierarchy. As such, some knowledge/power is considered more dominant and legitimate and is, therefore, privileged. This process is, however, often capricious resulting in unequal power relations, as certain knowledge becomes privileged over others at various times (Foucault, 1978).

Certain scientific discourses have normalising effects. They dictate appropriate behaviours such as 'normal' weight or 'normal' sexual practices.

Subjectification is the result of the internalisation of these norms. By aspiring to

normality through modifying our behaviour, we become individual subjects. Norms minimise individuality, reducing subjects to a bell curve.

2.6.4. Biopower

In Foucault's *History of Sexuality* (1978), he challenged the view that our experiences of sexuality were in need of liberation from the repressive mechanisms of power. Foucault asserted that sexuality only exists in society and, as such, our experiences of sexuality are the direct result of mechanisms of power and cultural practices. To challenge this idea of repressive power influencing sexuality, Foucault re-conceptualised the nature of power itself. The resulting claim was that power is productive, not repressive. It operates through normative practice and scientific discourse; the effect of which determines our perceptions of sexuality. The idea of productive power can be evidenced through Foucault's conceptualisation of biopower (Foucault, 1978). Biopower is a protective entity, a form of social control, which focuses on the health and wellbeing of a population. It regulates the life of subjects by medicalising them and bringing them within bio-scientific control. Biopower illustrates the socio-political control of people in contemporary society through the operationalisation of bio-scientific knowledge as an instrument of power (Foucault, 1978).

2.7. ETHICS AND PROCEDURE

2.7.1. Ethics

Ethical approval was received by the University of East London's School of Psychology Research Ethics Committee. Additional NHS ethical approval was not required due to the participants' position as clinicians within the NHS. In accordance with current ethical frameworks this group of individuals were not considered to be vulnerable. Established ethical practice was adhered to which included; obtaining informed consent from participants pre and post interview; adhering to confidentiality and anonymity guidelines around protecting the identity of participants, as such, all identifiable information was changed; and informing all participants of their right to withdraw from participation of this research study without any consequence.

2.7.2. Participants

2.7.2.1. Sample Size

Qualitative and quantitative research methods have very different expectations in relation to sample size, not least because of their (opposing) epistemological assumptions. While quantitative research gathers a thin amount of information from a broad subsection of people with the aim of uncovering an objective truth, qualitative research will study fewer people, but will seek a richness from the data that reveals a deeper understanding of phenomena (Baker & Edwards, 2012). The theoretical orientation of qualitative research means that it is difficult to predict the required sample size at the beginning of a research project. Often, a solution proposed to this dilemma is to continue collecting data until saturation is reached and no new information is identifiable (Baker & Edwards, 2012). This approach is not always possible due to time constraints placed upon the research and so a practical approach is adopted herein which considers temporal factors. This study attempted to adopt a pragmatic approach to the recruitment of a sufficient sample of participants to reasonably respond to the research questions outlined in section 1.8. Given the research forms part of a professional doctorate practical issues were considered when selecting the number of participants. These included interview length, time taken to transcribe and analyse the data.

2.7.2.2. Participant Selection Criteria and Recruitment

The research question determined the type of participants required for this study. A range of mental health professionals would have been appropriate however, from my clinical experience, the majority of psychological support offered to women experiencing difficulties with orgasm is either with clinical psychologists or psychosexual therapists. Participants from these professions were therefore recruited accordingly. A purposive sampling approach to recruitment was utilised, including snowball strategies (Tashakkori & Teddlie, 2003). Initial contact was made to a head of a NHS psychosexual service in a London NHS trust. They were sent an information letter⁹ which resulted in them making contact via email for more information. Following that preliminary discussion, recruitment was completed through word of mouth, and all but one

⁹ See appendix 3.

participant was recruited in this way. The final participant was recruited through an advertisement placed in the NHS faculty for sexual health's newsletter. The NHS provision for psychological support in relation to orgasm difficulty is relatively limited across the London boroughs, therefore there was a reduced number of professionals from which to recruit. As such, it proved a challenge to ensure the recruitment of a sufficient number of participants. Nevertheless, strict inclusion criteria were set to ensure that participants were in possession of a recognised professional qualification, i.e. they were a qualified clinical psychologist or psychosexual therapist. They were also required to be currently working with women experiencing difficulties with orgasm in an NHS sexual health service. Once the participants had been identified, they were sent an information letter¹⁰ which contained the details of the study. During the initial contact with the participants, a mutually convenient time was arranged for the interview to take place in their place of work, which was located in an NHS building. Preliminary questions were also asked at this stage to ensure they met the inclusion criteria.

2.7.2.3. Profile of Participants

Eight participants were interviewed for the purpose of this research project. This is considered to be an appropriate number of participants based upon the concept of saturation (Guest, Bunce & Johnson, 2006). Seven of the participants were female, one was male. Six participants were clinical psychologists and two were psychosexual therapists. Seven participants worked in London, NHS, sexual health clinics and one worked in a charity setting. Whilst the professions themselves were limited to clinical psychologists and psychosexual therapists, the breadth of their experience was extensive. The participants were located across a number of pay bands, including newly qualified staff, through to service leads. This meant that the number of years of clinical experience ranged from less than one year, to over 15 years. Due to the limited number of clinicians working in this area, providing any more specific and individualised information on length of service could, potentially, jeopardise the anonymity of the participants.

¹⁰ See appendix 3.

2.7.2.4. Profile of the Researcher (Sensitivity to Context)

I identify as a white-British, female, trainee clinical psychologist from the University of East London (UEL). As a UEL trainee, I position myself as a critical psychologist. My interest in female sexual satisfaction began during my third year undergraduate degree when I embarked upon a dissertation which discursively explored how women construct their social reality in relation to orgasmic experience. The clinical psychology doctorate incorporates a critical element to its teaching which inspired me to think more deeply about female sexuality and reengage with this area. As such, I requested a specialist placement in a sexual health service for my third year placement and chose to continue my interest in female orgasm into my doctoral thesis.

My hope is that continuous consideration of my critical realist social constructionist epistemological position and broader context, including those of my participants and the interactions between them, as well as implications for subjectivity, has enabled me to minimally influence my data. The use of open ended questions would have reduced any constraints or preoccupations I, as the interviewer, may have imposed, thus enabling the participants to provide open and honest views in relation to the interview topics. Additionally, there were a number of factors which may have helped resist the potential subversion of the participants' positions as unequal in the researcher/participant relationship. Namely, these factors could be identified as my trainee position, which immediately positions me as less experienced in terms of my professional qualification and clinical experience compared to the participants. The fact that the interviews were conducted in the clinics of the participants may have been favourable to them. Additionally, my relatively limited experience (at the time of the interviews) of working directly with women seeking treatment for difficulty with orgasm immediately positions the participants as possessing a greater degree of experience to draw upon during our discussions. Had I been an equally experienced clinician, it may have been possible that the assumption of a shared knowledge could have prohibited the disclosure of certain information. My hope is that my position as an inexperienced clinician meant no such assumptions of my knowledge were made. As I began my placement, and analysis, I found myself entering into an insider-researcher position. This was through aligning with my fellow colleagues as we shared similar struggles when

working with this presentation. In this way, the insider-researcher position became invaluable for establishing a level of authenticity and reflexivity throughout the research (Bonner & Tolhurst, 2002).

2.7.3. Data Collection

2.7.3.1. Interviews

The decision to use interviews as a method of data collection was made after synthesising the arguments for and against this approach. A qualitative interview is one effective method to elicit the views and attitudes of individuals. It supports the researcher to achieve a particular level of depth that is not accessible by other approaches (Byrne, 2004). Further justification of qualitative interviews draws upon feminist theory and asserts that this method is particularly salient to researchers who want to explore the subjugated or misrepresented voices and experiences of individuals (Byrne, 2004). In line with this position, and in accordance with the epistemological underpinnings of this study, a constructionist approach to knowledge generation has been adopted herein (Kitzinger, 2004). In the context of qualitative interviews constructionism can be defined as the process by which the interviewee is given an opportunity to construct their version of the world in the context of the posed question (Silverman, 1993). Kitzinger (2004) furthers that what individuals' say during the course of an interview "should not be taken as evidence of their experiences, but only as a form of talk – a 'discourse', 'account' or 'repertoire' – which represents a culturally available way of packaging experience" (p.128). As such, a constructionist approach when interviewing is not a means by which one can identify the 'truth' or apparent 'realities', rather a particular representation of an individuals' perspective.

In total eight conversational interviews were completed for this study. Whilst they were conversational in nature they were also, at times, guided by a broad list of topics that were deemed relevant to the literature review and research questions posed. The interviews were conducted at the participant's place of work at a convenient time for them, and were recorded using two audio recorders. Each interview started with a question about the reasons why the participant's volunteered to take part and ranged from 46 minutes to 86 minutes, with an average time of 61 minutes. The interviewee was asked at the

beginning of the interview how much time they had available to talk, therefore the length of each interview was mutually contracted. The interviewee was asked five minutes before their chosen timescale if there was anything else they wanted to discuss prior to the completion of the interview. Consent was discussed and sought prior to commencing the interview and also upon completion, so that consent was truly informed. An opportunity for questions and reflections was made available at the beginning and end of the process. All recordings and transcriptions were kept securely in a locked filing cabinet. Upon completion of the study all recordings shall be destroyed (May 2016).

2.7.3.2. Transcription

Interviews were transcribed verbatim using Malson's (1998) transcript conventions. This simplified approach to annotation facilitated the readability of the data, but also allowed for meaningful additions to be recorded, such as pauses and interjections. Malson's guidance for transcription includes the following directions: "Sounds such as 'mm' and 'uhr' are transcribed phonetically, as are colloquialisms, abbreviations, stutters and half-said words. Where utterances are not grammatical, punctuation is used so as to make the transcript as readable as possible" (1998, p.xv). All personal identifiable information was altered to ensure anonymity and pseudonyms provided for all participants.

2.7.4. Analysis

As there is not one correct or privileged way of conducting an FDA, the analysis herein was informed by both Arribas-Ayllon and Walkerdine's (2008) discussion of how to complete an FDA, and Willig's (2008) six stage process for an FDA. As such, I have created a set of flexible guidelines for the analysis of data, subjectivity and practices.

The recorded interviews were listened to before engaging with the transcription process. After transcribing the interviews, the transcriptions were then read in conjunction with the recorded interviews, partly to ensure the accuracy of the scripts, but also to facilitate a reflexive engagement with the data. This process, therefore, became the initial stage of analysis and was facilitated through the use of a reflective journal which was used to note any points of interest. A reflexive approach was adopted when reading, and re-reading, the transcripts,

which also required me to ask particular questions of the data according to the theoretical concepts identified by Foucault and orgasm literature. These questions, or analytic foci, formed a number of stages and were as follows¹¹:

1. What is the object being constructed in the talk?
2. How is the object being constructed in the talk?
3. What is the function of this construction?
4. What subject positions are being made available?
5. What are the processes of subjectification?
6. What are the technologies deployed in the talk, and what are the implications for social practice?

The corpus of data was transcribed and analysed in its entirety by engaging with this process. The first question was initially used to analyse the data and explored all constructions of relevant discursive objects according to the main research question (clinician, therapy/practice, women, orgasm):

“How do clinician’s construct their understanding of therapy with women experiencing a lack of orgasm?”

Following this stage, a process was used to map the varying constructions of discursive objects, for example: orgasm as complex/misunderstood/important, therapy as individualising/pathologising/helpful, and clinicians as experts/failing/systemic. This process made engagement with the research question easier and facilitated the examination of the different ways in which the clinicians constructed their understanding of therapy. These were threefold; in relation to their practice; the women they ‘treated’ for orgasm difficulty; and the broader service context. The final five stages, or analytic foci, were then performed on the data based on the various constructions of the discursive objects. The write-up signified the final aspect of the analysis as certain extracts were selected over others. This process facilitated the clarification of ideas as appropriate extracts were selected which answered the research questions. As such, the analysis chapter pays particular attention to the ways in which clinicians constructed their understanding of; themselves as therapists; women and their difficulty with orgasm; and the wider structures within which

¹¹ See appendix 8 for a further explanation of these analytic foci.

they are located. The rationale for this was to explore the implications for the treatment, subjectivity and practice of these constructions.

2.7.5. Issues of Reflexivity

Coffey and Atkinson (1996) argue for a documented methodological account in order to provide an opportunity to inspect the integrity of the research, which is often accomplished through keeping a reflective journal. As such, a reflective journal has been kept throughout the research journey to facilitate consideration of personal and epistemological reflexivity and to increase self-reflectiveness. The final chapter will examine the effectiveness of this approach to reflexivity.

CHAPTER THREE: ANALYSIS AND DISCUSSION

This section contains a brief review of the analytic approach and structure of the analysis. The structure is organised within three discursive sites that together seek to address the research questions.

- Clinicians' constructions of their practice in relation to being a therapist
- Clinicians' constructions of their practice in relation to working with women who present as experiencing difficulty with orgasm
- Clinicians' constructions of their practice in relation to service context

Taking a critical realist social constructionist position, I used a Foucauldian Discourse Analysis (FDA) to examine the data which afforded a focus on how the social world, expressed through language, is affected by various sources of power (Willig, 2008). Within this position, I acknowledge that this process, in its entirety, is a result of my own personal historical and cultural context (Van Dijk, 2011). While methodologically rigorous, it must be acknowledged that, through a Foucauldian perspective, discursive practices constitute *all* forms of knowledge, including this analysis. Consequently, this thesis is itself a discursive construction which *authors* knowledge through my positioning (Willig, 2008). A reflective awareness of my own knowledge claims, and the discourses used to construct them, has been attended to. It is worth acknowledging, therefore, that this is one of many possible interpretations of the data presented.

The analysis is structured around clinicians' constructions in relation to their identity, their work with women experiencing difficulty with orgasm, and their position within wider service structures. The extracts will be presented in line with these three discursive sites to aid comprehension. Participant identification was coded into number (1/2/3), sex, (F/M) profession (ClinPsy – clinical psychologist or PsySexT – psychosexual therapist), for example (01FClinPsy). Each extract was examined using the methodology outlined in the previous section, but in summary, included consideration of how objects were constructed and the functionality of said construction, the subject positions

constructed by various discourses, the implication for subjectivity and the technologies of power used, and to what effect.

3.1. Clinicians' Constructions of their Practice in Relation to Being a Therapist

The extracts demonstrate the multitude of ways in which clinicians constructed their practice within the field of psychology. A particular effort is made by clinical psychologists, and psychosexual therapists, to delineate their roles from one another, and to justify the validity of their respective professions within the clinical area of sexual health. Clinical psychology is constructed as a profession that should aim to be comparable to medical doctors. The realisation of this aim is, however, met by tangible barriers. The extracts selected will explore the different discourses being deployed within the various constructions, while considering their implications for subjectivity. The types of social action that are warranted from these subject positions shall also be attended to, as well as the social action that these subject positions preclude (Willig, 2008).

3.1.1. Contest for Professional Hierarchical Dominance

Extract: 1

01FClinPsy:... *whenever you go to a training and there's sexual and relationship therapists, or relationship counsellors, clinical psychology, you do get a sense of being quite othered in the room, you know, in terms of, ideas about governance or research, or just the way we formulate feels a bit different (99-101).*

This extract details a clinical psychologist constructing her experience of attending sexual health training with other psychosexual clinicians. She talks of “*being quite othered in the room*” which is reminiscent of Foucault’s construction of othering and is connected to knowledge and power. Through the process of othering a hierarchical structure is inferred in which the potential strengths and weaknesses of the respective groups are highlighted. This process can be considered a technology as it ensures the power relations remain consistent

and pursues a political agenda of domination and colonisation; the superior versus the inferior (Foucault, 1978).

Subjectification refers to the process and formation of the individual subject (Kendall & Wickham, 1999). The processes of subjectivity seek to explain the construction, or technologies of the self (the specific practices by which subjects constitute themselves within and through systems of power). Based on these theories, we can hypothesise that the clinical psychologist in extract 1 is constructing her position as a professional within psychosexual health as “*othered*” and, therefore, a member of the ‘out-group’. Her location in the ‘out-group’ can be contrasted to the position of “*sexual and relationship therapists, or relationship counsellors*” who occupy the position of ‘in-group’ and, therefore, have more power as a professional group working in this field. This functionality of an outsider discourse to construct her sense of feeling “*othered*” creates the subject positions of non-expert. Clinical psychologists working in sexual health is considered a relatively new development in which the profession has less presence compared to psychosexual therapists. The implication for subjectivity of taking such a position will be attended to by the following extract.

Extract: 2

07FPsySexT:... [clinical psychologists] *refer to me and I refer to them, but I’m more likely to refer to them if a patient is HIV positive, if there is health anxiety, or HIV related anxiety, err but they will refer sexual dysfunction to me so the simplest answer to that is they don’t have the training to work with sexual dysfunction so they prefer I do it which is fine* (327-330).

The psychosexual therapist in this extract has constructed the differences between the ‘in-group’ (the psychosexual therapists) and ‘out-group’ (clinical psychologists) in relation to working with psychosexual issues. She has explained how clinical psychologists “*will refer sexual dysfunction*” to her because “*they don’t have the training to work with sexual dysfunction*”.

Psychosexual therapists are positioned here as the experts in working with psychosexual issues, while clinical psychology are conversely positioned as non-experts. By drawing upon an outsider discourse the psychosexual therapist can be seen to further cement the non-expert and ‘out-group’ position

of clinical psychology by reinforcing their collective sense of identity, and 'in-group' position, within traditional mental health presentations. This is performed by highlighting their expertise in working with "*health anxiety, or HIV related anxiety*" in contrast to "*sexual dysfunction*".

It can be hypothesised that particular social actions are warranted, and precluded, based on the subject position taken up by clinical psychology as non-expert in the field of psychosexual issues. If clinical psychologists are compared unfavourably to psychosexual therapists as non-expert, and continue to draw upon an outsider discourse, they may have less stake in this particular clinical health area. The implications for subjectivity for clinical psychology could, therefore, be argued to have less power than psychosexual therapists in determining how women with sexual difficulty are supported. Extract 3 demonstrates a clinical psychologist resisting this subject position.

Extract: 3

01FClinPsy:... *actually the way we [clinical psychologists and psychosexual therapists] work clinically is quite shared, but we can't, you know, but I guess the idea about understanding mental health perspectives, understanding health anxiety, erm, that kind of psychological theory underpinning is very different, but actually in terms of how you might approach work with a patient it is quite similar, but then there could be, obviously, you know, the patient seems to be changing their mind a lot, or really irritated by the patient, there might be less scope to think about personality factors or is it actually something like health anxiety (121-126).*

In this extract the clinical psychologist is constructing their practice as clinically "*quite shared*". This construction could be understood as clinical psychology attempting to join with the powerful 'in-group' by identifying similarities between them. The speaker in extract 3 then goes one step further and 'others' psychosexual therapists, as a profession, by undermining their training in comparison to clinical psychology, as not providing "*scope to think about personality factors*". The effect of this construction creates an alternative subject position to those eluded to in extracts 1 and 2, and allows clinical psychology to appropriate an expert position whilst imposing the non-expert

position on to psychosexual therapy. The analysis of extract 4 explores further the implications for subjectivity and practice of these constructions.

3.1.2. Clinical Psychology as ‘the Experts’

Extract: 4

05FClinPsy:... *so I wonder if it's in rejection of all of that [psychodynamic theory] and trying to make ourselves scientific and all of that sort of things you need to be proper and do a good job, and I guess particularly connected to pay bandings and this on-going competition trying to get for our pay bandings to be more equivalent to doctors than with people who are, with inverted commas, less well trained, erm, that we get a bit more sciency and a bit away from mad ideas like how some people perceive Freud's (230-235).*

It is necessary to provide some context before we analyse this extract as psychosexual therapists are often trained using a psychodynamic theoretical approach, whereas clinical psychologists are afforded the opportunity to develop skills within multiple theoretical approaches, such as; cognitive-behavioural, systemic and psychodynamic theory. In extract 4 the speaker is highlighting the professional move away from psychodynamic theory towards a preference for a scientific, rigorous, theoretical approach (*it's in rejection of all of that and trying to make ourselves scientific*). The speaker is also constructing other therapists who work with psychosexual difficulties as “*less well trained*”. The speaker in extract 4 is constructing clinical psychology as “*sciency*” with the implication being that other psychosexual therapists are not, because they are heavily influenced by the “*mad ideas*” associated with Freud and psychodynamic theory. Here, the requirement to be “*sciency*” has been conflated with being “*proper*”, doing a “*good job*” and ultimately, a professional alignment “*equivalent to doctors*”.

These constructions of the role of clinical psychologists as scientist-practitioners who aim to be more aligned to medical doctors can be located within a biomedical discourse which privileges medical knowledge, science and universal truths. The speaker's preference for a “*sciency*” approach to psychology can, therefore, be located within a realist epistemological position which is congruent with biomedical approaches and resulting discourse. Rose

(1999) asserts that an expert stance is derived from a position in which there exists desire for self-development. An expert position is driven by expert knowledges, underpinned by objective truths which serve to define the parameters of 'normal' behaviour (Foucault, 1990). The expert position affords the profession knowledge and thus power, which reinforces and cements them in a hierarchical position akin to medical doctors. The aspired expert position is problematised in extract 5, as clinical psychology, within the context of psychosexual difficulties, is constructed as fallible.

Extract: 5

05FClinPsy:...so erm, evidence base (for systemic therapy), less clear-cut, erm, with the up rise of CBT therapies etc. etc. we need to be able to compete although ironically we can't because we're actually not considered as good and we don't have BABCP¹² accreditation with that, that hasn't really worked very well. Erm, one to one work, stuff that's easy to label; depression, anxiety, is clearer-cut, I think evidence and research has been a bit better at demonstrating how that affects what society is interested in like functioning and going to work (86-91).

The speaker in this extract positions the dominant therapeutic approach within clinical psychology as CBT (*the up rise of CBT therapies*) and how it is privileged over systemic approaches because of systemic theory's "*less clear-cut*" evidence base. For context, CBT is considered to be more aligned to a biomedical perspective of mental health, which privileges working at an individual level (Ryle, 2012). Systemic theory, conversely, is positioned towards a relativist, epistemological position and privileges the contextual factors which may be impacting upon a person's wellbeing. The speaker in extract 5 is constructing clinical psychology as being "*not considered as good*" as those CBT therapists whom have "*BABCP accreditation*"; a factor which she considers has made clinical psychology less competitive as a profession (*we need to be able to compete although ironically we can't*). The speaker then goes on to construct how "*evidence and research has been a bit better at demonstrating*" the impact of mental health difficulties, like depression and anxiety, on daily functioning. The implication here is that psychosexual

¹² British Association of behavioural and cognitive psychotherapies

difficulties are less easy to label and, as such, research has been less effective at demonstrating the economic impact, such as “*going to work*”. The result of employing this economic discourse means that the subject positions of being “*sciency*” and “*proper*” in order to do a good job are undermined in this particular clinical field because psychosexual issues are less scientifically clear-cut. Consequently, clinical psychology’s position as expert and competitive becomes compromised, when compared to psychosexual therapists and CBT therapists who are BABCP accredited. This accreditation affords professions with the ‘power/knowledge’ as they are granted an ‘ology’ which positions them as expert. The implication for subjectivity, therefore, is that the professional power of clinical psychology is diminished by reason of their knowledge base being less valued. This has repercussion for pay bandings and the aspired alignment to medical doctors (extract 4).

In summary, this section has presented and discussed the analysis through attending to clinicians’ constructions of practice in relation to being a therapist. The clinicians’ constructed their practice in a number of ways. These were in relation to securing professional dominance over similar professions, and by taking up the subject position as ‘the expert’. The next section shall present the analysis and discussion which seeks to understand how clinicians construct their work with women who have difficulty experiencing orgasm.

3.2. Clinicians’ Constructions of their Practice in Relation to Working with Women who present as Experiencing Difficulty with Orgasm

This section will use Foucauldian insights to demonstrate how clinicians constructed their experience of women who present as having difficulty with orgasm, and the effect of these experiences on their ability to be an effective clinician. The failings of clinicians are constructed as the responsibility of training courses in not providing adequate teaching on psychosexual matters. The extracts also highlight the effects of heteronormativity, patriarchal power, normalisation, and resistance (concepts which shall be attended to in more detail herein).

3.2.1. Orgasm as a “Heart-Sink” Referral

Extract: 6

03FClinPsy:... *Anorgasmia, it's really difficult, it's awful isn't it? I don't want to sound pessimistic, but it was a relief when my colleague said to me, who was my supervisor at the time, anorgasmia was a heart-sink referral because I felt it too. It was one of the things that you just felt always probably a bit unsure about how to work with actually because there isn't anything that descriptive because there's not a lot of research out there we don't really know what we're doing and if it's helpful cos there's no outcomes so it's all very anecdotal and you know what works for who and you know the next person along, erm, whereas you get an ED [erectile dysfunction] referral and feel quite confident maybe because you experienced these things at work, maybe it's just a lesser complex issue, I really don't know, but it is funny that it is perceived as one of the more heart-sink referrals and it must feel, I would hate the client in a sense to hear that that even the person whose meant to be able to help them overcome this is probably their sense, erm, thinks "oh God, what do I do with this" (592-602).*

In extract 6 the speaker constructs both the client and the presentation as problematic (*it's really difficult*), and as “heart-sink”. “Anorgasmia” is constructed as problematic in the way that it is difficult to treat (*Oh God, what do I do with this*). She also shares how there is “*not a lot of research out there*” to support treatment and “*no outcomes*” to evaluate treatment effectiveness. The speaker hypothesises the reason for this, and compares difficulty with orgasm with erectile dysfunction. She constructs erectile dysfunction as “*a lesser complex issue*”.

Consequently, women unable to experience orgasm are afforded the subject positions of ‘problematic’ and ‘untreatable’. These positions could be argued to create negative implications for subjectivity, given how the speaker asserts that she “*would hate the client...to hear that*”. Simultaneously the speaker is positioning herself and her profession as failing and unhelpful (*we really don't know what we're doing with this*), which is likely to affect morale, confidence and enthusiasm for this type of work. The term “heart-sink” is incredibly

powerful as it evokes a sense of fatalism and hopelessness. In addition, we can see from extract 7 that the training provided to clinical psychologists is constructed as not privileging this clinical area, which may further impact upon the development of clinicians who feel skilled to work with this presentation.

Extract: 7

05FClinPsy:... *I do want to acknowledge that the training courses have got a huge number of agendas and stakeholders and they've got loads of stuff to balance, so I do feel I've had very good training in many many important ways, erm, at the same time, any course ends up having higher contexts that they privilege and one that's very lower down on that, from my perspective, is around sex and relationships, erm, by relationship I guess I mean particularly couple relationships. So, for example, I've only been qualified three years and we had a half day around couples, that I can remember, erm, which is very very different to the amounts you would get over even work with families or in certainly much much less than you'd get in one to one work (76-84).*

The speaker in extract 7 constructs clinical psychology training courses as not prioritising teaching “*around sex and relationships*”. In this sense, the training courses could be understood as a purveyor of disciplinary power, in that it is defining what is valued, or ‘normal’ psychological work, and aimed at the training of individual bodies; in this case, clinical psychologists. The effect of this disciplinary technology, therefore, marginalises and subjugates the psychosexual field as a less valid and privileged area of psychological interest through the result of a lack of research, and therefore knowledge and power.

3.2.2. Normative Constructions of, and Implications for, Female Sexual Experience

Extract: 8

04MPsySexT:... *we think that it's also proven, you know, it seems to have been, well if we think about (sigh) we're going back aren't we, to men biologically needing to spread their seeds and women needing to feel as though this is a good a good provider of sperm for my baby, now whether that means they would need longer to be erm, to be stimulated I*

don't know, is the answer, I don't know, I mean you know if they could check the bank account (smiling), I don't know (260-265).

The speaker in extract 8 is constructing his practice as informed by science (*we think that's also proven*) which can be located within a biomedical or expert discourse. He is also drawing upon heteronormative, stereotypical and patriarchal ideas of relationships to inform his knowledge and practice. Examples of this can be seen through his use of the male sex drive discourse (Holloway, 1984), which understands male sexuality as an insatiable biological drive. The speaker draws upon this discourse through his characterisations of men as taking the role of being a “*good provider*” for women, in both reproductive (*sperm*) and financial terms (*if they could just check the bank account*). This talk produces subjugated forms of subjectivity for women as they are positioned as subservient, or victims, to penis/man's power, whilst the speaker is positioned as expert as he draws upon a biomedical discourse (*it's also proven*). This privileged expert knowledge, generated from within a biomedical and, therefore, androcentric framework, utilises disciplinary technologies which subjugate women through the development of norms (Malson, 1998). The desire to avoid being labelled as ‘abnormal’ motivates women to ascribe to such norms, a process facilitated through self-regulation. The implications for subjectivity, therefore, mean that women become attached to these norms because they are tied to a central component of normative female identity. As such, patriarchal power takes effect by attaching women to certain paradigms of feminine identity tied up with subservience and not needing to be sexually stimulated. This is constructed through the talk: (*women [need] to feel as though this is a good provider for my baby*). In this way, female sexuality becomes tied to procreation and orgasm becomes constructed as unnecessary and redundant.

Foucault (1978) wrote about the emergence of sexualised identities in the 19th Century. He maintained that the rise of capitalism, and the requirement to produce a workforce, coincided with the emergence of sexuality at this time. Anything which prevented the production of a workforce became problematised, and examples of this can be seen in the construction of the ‘homosexual’, for example. Sexuality, thus, became salient, due to the requirement to control and

study the population, which resulted in the medicalisation of certain areas of life and brought it under bio-scientific control; a technology Foucault referred to as biopower (1978). Resulting knowledge from biopower acts as an instrument of power and supports the socio-political control of people in society. As such, one could understand the speaker in extract 8 as constructing women's sexual experience as 'unimportant' in relation to men's sexual experience. Through positioning women as focused on finding a "*good provider of sperm*" for procreation, or "*checking the bank account*" to ensure financial protection, he is minimising her need for sexual satisfaction. A women's inability to experience an orgasm is, therefore, constructed as 'unimportant' in the context of women as reproductive, while the converse could be said for men, as was demonstrated through the speakers use of male sex drive discourse.

Extract: 9

01FClinPsy:... *or Tiefer's ideas of new view of sexuality and could foreplay actually just be play and could that kind of sex be sufficient and pleasurable and enough and does it have to be penetrative intercourse and does it have to be orgasm and I think even for myself when I say that I'm like, I know that I've been socialised in the same way and I'm kind of like, well YEAH, you know (laugh) (450-454).*

The effects of normalisation, a technology of the self, can be seen within extract 9. The speaker presents an alternative construction of sexual pleasure to that of heteronormative practices, such as the coital imperative (*does it have to be penetrative intercourse*) (Gavey et al., 1999). Heteronormative practices are often linked to reproduction. Reproduction requires penetration, therefore what is defined as normal sexual practice is measured against its reproductive worth.

Despite her attempts to promote Tiefer's 'New-View' approach to sexuality (Tiefer, 2010), in which oversimplified and medicalised messages about sexuality are challenged, the speaker acknowledges that she too has "*been socialised in the same way*", presumably as other women through the effects of normalisation, with the result being that orgasm through penetration is the only way for sex to "*be sufficient and pleasurable and enough*". As explained through the use of Foucault's concepts (1978) in extract 8, norms are usually aligned with political goals, thus the norm in this case would be for a women to

be sexually healthy, able to have intercourse and thus reproduce in order to sustain the economy. According to Bordo (2003), the discipline and normalisation of women, and the female body, is a form of social control. Women, she argues, struggle to resist, or shift, the power relations which position them in various ways according to gender configurations.

Extract: 10

02FClinPsy:... *not having an orgasm or in our kind of western way not achieving an orgasm, you know, could certainly be seen as a slur on your womanhood sort of, and I think a lot of women do experience it in that way, they feel lacking, they feel that they're not achieving, that they're not like a proper woman, that there's something wrong with them. Erm and yeah, I think we still erm, you know, and I guess part of that, part of what's so distressing for women about that is, you know, it affects how you view yourself erm it also affects how you view relationships and I think a lot of women express fears that if they, if they're not orgasmic in the right way that men won't want them or their partners might leave them for someone else (410-418).*

The speaker in extract 10 is constructing orgasm, and a lack thereof, as an entity and not a process. As something that can be achieved or not achieved (*our kind of western way not achieving an orgasm*). When we understand the constructions of orgasm in this way, in line with the regulatory effects of normalisation and biopower, we can see that orgasm becomes a potent signifier of a particular meaning of heteronormative penetrative sex. The institutional practices of patriarchy regulate the positions available to women and, through the effects of normalisation, positions them as problematic (*there's something wrong with them*). In this way, the inability to be “*orgasmic in the right way*” prohibits their womanhood (*not a proper woman*) and affects their self-image (*it affects how you view yourself*). The effects of a patriarchal and heteronormative discourse privilege male sexuality and affords them the subject position of ‘active’ in the dyad. This can be seen in the construction that if women do not comply with the sexual requirements, dictated through normalisation, as being “*orgasmic in the right way*”, “*their partners might (actively) leave them for someone else*”.

In these extracts a lack of orgasm is constructed as difficult (extract 6) because it is something women want to achieve to avoid feelings of shame generated by thoughts that “*there’s something wrong with them*”. Orgasm is seen as an achievement, as something that is equivalent to success. Extract 10 constructs a successful relationship as one in which women must be “*orgasmic in the right way...or their partners might leave them*”. To be unable to orgasm is akin to being a failure as a woman and so, in this sense, orgasm becomes a potent signifier of (un)successful women. One can, therefore, deduce that patriarchal power operates by ascribing identity of a successful woman to heteronormative orgasmic experience through the disciplinary technology of normalisation. I would, therefore, argue that these rules for what constitutes a successful woman operate to perpetuate male power.

3.2.3. The Liberation of Heteronormative Hegemony

Extract: 11

02FClinPsy:... *if you don’t have a perspective that’s able to think about women and power and who has the power to define what sex should be and how it should be then you can end up just individualising and internalising these things* (144-146).

Contrary to many writers, Foucault believed in possibilities for action and resistance (Rabinow, 1991). The challenge to power can be enacted by “detaching the power of truth from the forms of hegemony, social, economic, and cultural, within which it operates at the present time” (Foucault, in Rabinow, 1991. p.75). According to Foucault (1998), discourse can be a site of both power and resistance. “Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart” (Foucault, 1998. p. 100-1). An example of discourse as resistance can be seen in extract 12.

A feminist discourse is drawn upon in which a “*perspective that’s able to think about women and power*” is privileged. The assumptions, expectations and implications located within a feminist discourse facilitates the resistance of sanctioned and normalised experiences of female sexual satisfaction as always already heteronormative and linked to male sexuality. They instead, privilege one in which broader contextual factors and socio-political effects are

considered. A feminist approach moves away from biomedical treatments of sexual difficulty, rejecting the “individualising and internalising” nature of CBT informed approaches. Feminist approaches are one way to transform states of domination into strategic relations because they highlight the institutionalised nature of certain power relations, such as biomedical approaches like CBT. Emancipation from different states of domination happens through the questioning of inherent applications of normalisation techniques and self-regulation.

Extract: 12

05FClinPsy:... *I do try and bring other gender and sexuality into it, and whether their heterosexual stance is constraining, which is my personal belief that the scripts are very pre-scripted and have been passed on for years, reinforced in lots of unhelpful ways, and to be quite boxed in, we often find couples who are a bit more fluid in general sexuality norms play around a bit more, although it's terrifying because there isn't a script it's also quite liberating for them at the same time (542-547).*

Further examples of resistance to heteronormative hegemony can be located in extract 12. The heterosexual stance is constructed as being “*constraining*” and “*pre-scripted*”. The speaker refers to how these scripted and sanctioned expressions of heterosexual sex are “*reinforced in lots of unhelpful ways*”. An example of regulatory power is evident here. Heteronormative and patriarchal discourses make available certain subject positions which have implications for subjectivity. Those who take up the subject position created by these discourses in the context of sexual encounters as heterosexual, are limited to the social actions warranted by that position. As such, they have been constructed in this extract as subscribing to a pre-scripted expression of sexuality, and self-regulate themselves accordingly. This construction is contrasted with couples who are more “*fluid in (terms of their) sexuality norms*”, which is positioned as a “*liberating*” experience. Here we can see the effects of resistance to the dominant discourses through a counter-discourse. This has resulted in the construction of alternative subject positions which reject normalised heterosexual function of sex, bound by the reproductive and economic institutional requirements of biopower. This resistance is constructed as “*terrifying*”, however, because “*there isn't a script*”, or socially sanctioned and

normalised way to behave sexually. The risk, therefore, relates to the identification with the subject position of 'abnormal'.

In summary, this section has presented and discussed the analysis through attending to clinicians' constructions of women experiencing difficulty with orgasm. The clinicians' constructions involved considering the presentation as "*heart-sink*", the normative constructions of, and implications for, female experience in relation to orgasm absence, and liberation from heteronormative hegemony. The next section shall present the analysis and discussion which seeks to understand the wider institutional practices which regulate the practice of clinician's who work with women experiencing difficulty with orgasm.

3.3. Clinicians' Constructions of their Practice in Relation to Service Context

The previous sections have attended to how clinicians constructed their practice in relation to working in psychology, and how they constructed their practice in relation to working with women experiencing difficulty with orgasm. This final section aims to integrate these understandings within a meta-context of access to therapeutic services, by identifying how certain discourses are perpetuated at the broader institutional level and how these practices enable and constrain certain constructions. The types of social action that are warranted from these regulatory practices shall also be attended to, as well as the social action that these regulatory practices preclude (Willig, 2008).

3.3.1. The Subjugation of Women's Sexual Experience in Service Context

Extract: 13

02FClinPsy:... *I think there is so little say NHS provision for a psychosexual work right now and it seems to be getting less and less as time goes by. Erm, I've being working in sexual health since about 1998/1999 so, you know, a very long time and, erm, over the years I've just seen the provision get less and less (40-43).*

Extract 13 constructs the landscape of psychosexual services as changing for the worse. The speaker talks of how the number of NHS services offering psychological support for psychosexual difficulties is reducing (*I've just seen the provision get less and less*).

Extract: 14

03FClinPsy:...*there might be a first approach of a cheaper medical treatment and therapy for other sexual difficulties, but anorgasmia not, I guess, erm, so I don't see that the services are going to get any more commissioning I don't think, I think if anything it will go the other way,*

Interviewer: *because it's not seen as a life or death?*

03: *it's not seen as as important, I don't know, what does that go back to? Is it, why do women need to orgasm, are they, is there any functional reason they have to, men need erections to create children? (289-294).*

Sexual difficulty in women is constructed as unimportant by the speaker in extract 14. She constructs that this may be due to the absence of a “*functional*” need to orgasm compared to men who “*need erections to create children*”, and lack of “*cheaper medical treatment*” alternatives. This construction positions women’s sexual satisfaction as less important to that of males and can be understood as operating within a patriarchal discourse. This discourse has implications for the subjectivity of women, who may feel disempowered as a result, or that they are not entitled. In terms of implications for the practice of clinicians, these constructions may reinforce that women presenting with a lack of orgasm are; a) untreatable, because they do not respond to medical intervention (*there might be a first approach of a cheaper medical treatment and therapy for other sexual difficulties, but anorgasmia not*), b) not worthy of research and further explorations (*is there any functional reason they have to [orgasm]*), and c) not a priority for commissioning (*I don't see that the services are going to get any more commissioning*). These implications for subjectivity and practice are maintained by wider-contextual, institutional power, such as biomedicine, for example, which regulates the psychosexual field through discourses of efficiency, productivity, objective truth and reductionism.

Provision is constructed as providing a luxury service because women's bodies are constructed as consuming of orgasm, as their "*functional reason*" is questioned. This construction is juxtaposed with men's bodies who are constructed as productive following orgasm (*men need erections to create children*). This construction can be located within the wider institutional practices of capitalism, whereby contribution to the economy is privileged. In this way, women's orgasm is constructed as something which has questionable value for society and therefore, something that potentially does not warrant service provision. This process is an example of regulatory power and social control, as within capitalist consumer culture women are "continually besieged by temptation, while socially condemned for overindulgence" (Bordo, 2003, p. 199). Women are frustrated and seduced by a culture which markets and manufactures desire, but which refuses the consumption of it, so that they remain productive subjects. This presents a harsh dilemma for women following the separation of reproduction from sex in the 1960's, a dilemma which is not present for men's relationship to their sexuality in the same way.

3.3.2. The Dominance of Biomedicine in Service Commissioning

Extract: 15

08FClinPsy:... *commissioners maybe have tended to feel safer, or, or, like numbers and graphs and, err, data that can be measured in that way more, erm, or think that that's more powerful, meaningful or exciting, erm, because it fits more with peoples idea about science and rigour and all those sorts of things, erm. I think that I think that still holds true, but it's a bit of a shame, erm, because a lot of that research isn't very service user led or necessarily answering things that actually might be more interesting* (23-28).

The speaker in extract 15 constructs commissioners as feeling safer when they are presented with "*numbers and graphs and...data*". She constructs the reason for this perhaps being due to their link with "*science and rigour*". This can be understood as an example of governmentality whereby biomedicine produces a regulatory function through sanctioned forms of knowledge. In this way, scientific practices become valorised, thus maintaining its influence. The wider socio-cultural contexts of how knowledge is produced can therefore be

understood as imbricated in these discursive constructions. The implications for clinical practice is such that the therapeutic approach of CBT is privileged as it is most akin to the specifications of commissioners. CBT and the biomedical model are good bedfellows as they both subscribe to an evidence base, they are both approaches which locate the problem in the individual, and contain a certain assumption of individual pathology that needs addressing (Boyle, 2011). This mutually beneficial relationship can be seen to be occurring at the macro and meso level. Biomedicine, and its regulatory practices such as NICE guidance and the DSM (APA, 2013), operates at a wider contextual level, whereas CBT operates at a local level. The effect of this collaboration at multiple levels of context serves to obscure the institutionalised nature of these power relations, therefore, reinforcing it as a state of domination.

Extract: 16

08FClinPsy:... *it's [CBT] kind of rigorous because it's got a tendency to produce protocols or models, you know, fancy diagrams of you know this is CBT for orgasm and vaginismus, and that way you can really kind of, erm, market it, you know, it its then often training gets brought out of that and, you know, that you'll see, days for X or books on X, and articles evaluating that model and those ideas, yeah, it's it's very powerful (478-482).*

The speaker in extract 16 has constructed some of the reasons why CBT is thought to be privileged by commissioners. She constructs CBT as “*rigorous because it's got a tendency to produce protocols or models*”. These protocols produce a standardised way of working with a presentation that not only strives to eliminate error, but that also improves capacity for its evaluation. Another benefit of CBT, as constructed by the speaker in extract 16, is that psychology can “*market it*”, thereby making it profitable.

CBT's capacity for standardisation makes the approach increasingly marketable. This can be understood further through a governmental neoliberal regime of power which, on a local level, operates through technologies of the self. This is a Foucauldian concept which describes a mechanism in which individuals are induced to govern themselves and therefore need only limited direct governance by the state, through processes of subjectivity. An example

of self-governance could be through the consumption of self-help books, rather than through seeking a referral for psychological therapy. The primary agent of power here is the market, or capitalism for example. Expertise, therefore, can be considered a fundamental aspect of technologies of the self as it transforms the ways in which individuals construct themselves, through “inculcating desires for self-development that expertise itself can guide (Rose, 1999, p.88).

Implementation of these technologies is manufactured by experts from the social sciences, such as psychology. In this way, expertise located within scientific knowledge facilitates distance between the state and self-regulation. In line with neoliberal theory, success in life, therefore, becomes linked to continued freedom from the state. The consumption of a self-help book could be seen as an undertaking of self-disciplining, further regulated by the wider social institutional embodiment of power manifest in the workfare, rather than welfare state.

There are implications and social actions warranted for commissioners as a result of these technologies which transform individuals into self-regulating, neo-liberal subjects. By positioning the ‘problem’ as located within the individual, thus minimising the impact of contextual factors, there is less expectation and responsibility on the state to provide solutions. This may manifest as a reduction in the demand for services, as a consequence, thus moderating the financial expenditure on psychosexual therapeutic services. Women, as a neo-liberal subject experiencing difficulty with orgasm, may, therefore, turn to self-help material informed by CBT as a result of scientific expertise, which serves to further perpetuate the understanding of this ‘problem’ as being located within the individual. This, in turn, would create a vicious cycle, or technology of power, that women are unable to resist.

There is, however, a problem with CBT providing the answer to governmentality’s attempt to transform society into a neo-liberal state, as constructed in extract 17.

3.3.3. Processes of Resistance to Biomedical Dogma

Extract 17

08FClinPsy:... *I think quite possibly other approaches would be better suited to working with something like that [difficulty with orgasm] but, I*

think, they, things like systemic ideas but, traditionally they are not, the systemic model is not very good at, erm, demonstrating, in the way that is valued currently, you know, which is the whole point of what systemic ideas are about and what they are not about but yeah (sigh) (533-535).

This extract constructs the application of CBT as less well suited to the treatment of difficulty experiencing orgasm in contrast to “*systemic ideas*” which account for contextual factors and can be less pathologising. The speaker advocates the use of systemic theory although highlights a problem inherent with this approach; “*the systemic model is not very good at, erm, demonstrating, in the way that is valued currently*”. Demonstrating outcomes of therapy is something which has become important under the biomedical regime, a discursive shift which can be attributed to economic and efficiency agendas. CBT and other modernist approaches to therapy subscribe to a realist epistemological stance which, in relation to outcome measurement, assumes that an objective truth can be discovered. Foucauldian insights can be drawn upon here to understand this process further. Foucault described disciplinary technologies associated with power/knowledge (1977). Observation, or the ‘gaze’, produced power by observing subjects, whilst the ‘archive’ categorised them, resulting in such things as disease. As such, the ‘gaze’ and the ‘archive’ are technologies that achieve power/knowledge. Technologies of the body, therefore, facilitate power to be strategically exercised and can be considered the foundation of modernist science.

In summary, the speaker is constructing a CBT approach to treating difficulty with orgasm as less effective than a systemic approach, however, the double bind is that CBT produces outcomes for commissioners which are more valued than those generated through the use of systemic models of therapy. CBT can be considered a disciplinary power due to its individualising, homogenising effect. In accordance to the normalising function of disciplinary power, CBT identifies deviations from the norm as pathological. Therapy, therefore, becomes a site of persistent examination which, in turn, produces knowledge which itself becomes a vehicle of power: “the examination is, as it were, the ceremony of this objectification” (Foucault, 1977, p.187). The implications for subjectivity can be understood through Foucault’s technologies of the self, a governmental power which acts to produce self-referential subjectivity.

Foucault writes that, “this form of power applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attached him to his own identity, imposes a law of truth on him that he must recognize and which others have to recognize in him. It is a form of power which makes individuals subjects” (1982, p.781). As a technology of the self, CBT imposes a law of truth onto the individual and marks them by their own individuality. The implications for the subject positions afforded to women experiencing difficulty with orgasm therefore become ‘abnormal’ and ‘pathological’. Under the biomedical dogma the implication for clinical practice of these subject positions means that the therapists construct the women as ‘untreatable’, due in part, to the absence of contextual factors.

Extract 18

05FClinPsy:...*Erm, one to one work, stuff that's easy to label; depression, anxiety, is clearer-cut, I think evidence and research has been a bit better at demonstrating how that affects what society is interested in like functioning and going to work (88-91).*

Extract 18 continues to construct the highest context for commissioners as being economical (*society is interested in...functioning and going to work*). Difficulty experiencing orgasm for women is once again positioned as something not “*clear-cut*” which constructs it as less compatible to a standardised CBT model. The economic discourse privileged by commissioners appears to be incongruent with a relational and contextual approach to supporting women who are distressed by their experiences of orgasm difficulty. This may be due to the efficiency generated by the homogenising practices of normalisation, which is driven by a modernist stance to knowledge and the identification of universal truths. The privileging of an economic discourse potentially positions clinicians in an impotent position, as to receive money they need to demonstrate measurable outcomes in the way that CBT can. Yet we can see from the constructions discussed herein that CBT may not be the most appropriate approach to support women with this presentation. We can see further evidence of the construction of this in extract 19.

Extract: 19

03FClinPsy:...[if there were no service constraints] *I think we'd offer people a lot longer term, work, I don't know how helpful it would be with anorgasmia, I certainly think you can't really do a lot in the five sessions that I worked with in the other model, I don't know how long you'd need, I mean, my sense is, I don't know, in my experience I think a lot of the time people have tended to go on to longer term, therapy anything with things like this, if they've not really got to where they want to with anorgasmia, so maybe that says something about it and maybe it says more about how complex an issue it is, is it anorgasmia or is it just, you know, what is anorgasmia, is it that it's about not having an orgasm erm, I would say it isn't really, it's you know it's much more complex than that and maybe that warrants why people would go on and have something more longer term (517-525).*

Once again the speaker in extract 19 constructs “anorgasmia” as a complex issue that is about more than the entity of orgasm (*it's much more complex than that*). The speaker also references the “five session” model used adopted for working with psychosexual issues. Many services offer constraints around the number of therapeutic sessions a presentation can be offered. This is often in response to NICE guidance. Foucault's work on governmentality (1979) may be useful in explaining the operation of evidence-based health care and the internalisation of clinical guidelines relating to best practice for those seeking treatments, such as NICE guidance. Clinical guidance can, therefore, be considered an example of regulatory power at the level of the institution. Through continual evaluation, observation, audit and inspection, a mode of social control can be implemented. The individual then internalises the conscious awareness of surveillance, and self-regulates themselves into performing in such a way that is in accordance with clinical guidelines in order to avoid punishment.

The rationale of science to engage in this process can be constructed in a number of ways. One of which might be through the sciences assertion that it is a superior knowledge. For this assertion to be ‘proven’, science created rigorous criteria against which concepts could be evaluated, thus transforming their knowledge into ‘truth’. This process can be seen in the circular nature of

research informing treatment which is evaluated against the same criteria with which the original research was produced. The result, therefore, reinforces the constructed validity of science. While CBT as a therapeutic approach is concordant with modernism, systemic approaches do not operate within the same knowledge claims, and are thus disadvantaged as an appropriate therapy, within an economic and biomedical discourse.

3.3.4. The Effects of Governmentality on Clinicians Practice

Extract: 20

08FClinPsy:... *if there's no guidelines about it, that impacts commissioners, that impacts people's confidence working with it, people's awareness of it as a problem that is, erm, you know, should be kind of given, erm, kudos, or whatever the word is, erm, so yeah, maybe that's where all this starts* (184-187).

There are no clinical guidelines offering standardised treatment for working with women presenting with difficulty experiencing orgasm. The speaker in extract 20 constructs this as problematic as it "*impacts commissioners, that impacts people's confidence working with it, people's awareness of it as a problem*". As already discussed, the concept of governmentality (Foucault, 1979) can be used to understand how populations are governed indirectly through expert knowledge, such as psychiatry (Foucault, Burchell, & Gordon, 1991). Once again, the biomedical model, and CBT, can be considered as the dominant approaches to psychology. The notion of subjectivity posits that the dominant truths and knowledge associated with these approaches are readily internalised, resulting in self-disciplining behaviour, while subjugated knowledges offer the possibility of contest and resistance to dominant discourses (Fischer & Ferlie, 2013). The absence of published guidance in the treatment of 'female orgasmic disorder', does not perpetuate the position of science, and thus biomedical approaches, as the purveyor of valid and objective truth.

Extract 20 demonstrates the process of subjectification as the speaker internalises the dominant biomedical discourse in an attempt to re-form themselves through adherence to its rules (*if there's no guidelines about it...maybe that's where all this starts*). Through this construction it appears that

science's influence is positioned as diminishing as a result of there being no clinical guidance. In terms of subjectification, her accordance to a biomedical discourse, in which she constructs standardised clinical guidelines as important, demonstrates the internalisation of dominant knowledges, through self-disciplining behaviour under the regulatory power of biomedicine, in an attempt to adhere to its rules and gain confidence through an expertise position. The implications for subjectivity are such that the speaker constructs a need to establish clinical guidance in the form of expert knowledge as a priority and place to start. In so doing, science can once again assume the dominant position through the power/knowledge nexus formed through the circularity regulatory and disciplinary technologies: research informing treatment, treatment evaluated against the same criteria with which the original research was produced.

In opposition to the effects of self-regulation, extract 21 provides an example of subjugated knowledge offering resistance to dominant discourses around privileged approaches to psychological therapy.

Extract: 21

05FClinPsy:... *I very much, on a political level I guess, as well as what I think is useful for the client, will talk around how I think societal ideas around discourses and messages around sex are part of the problem and although we may not be able to shift them, erm, thinking around how we chose to relate to them, which messages we prefer to privilege and so forth (269-273).*

This extract demonstrates the speaker constructing their practice in relation to difficulty with orgasm by drawing on a feminist discourse. We are witness to an act of resistance in which the sanctioned and normalised therapeutic approach of CBT is assuaged in place of one which considers contextual factors and the “*societal ideas around discourses and messages around sex [which] are part of the problem*”. Having said that, the speaker makes an interesting comment which serves to minimise the construction of her usage of systemic theory: “*although we may not be able to shift them*”. This comment appears to be constructing systemic therapy as ineffective at completely shifting the “*societal ideas...and messages around sex*” that are “*part of the problem*”. This caveat

can be understood as the effects of disciplinary power and self-regulation whereby the speaker is not fully resisting the dominant treatment approach. Whilst the apparent lack of confidence in systemic therapy that has been constructed herein may be attributable to a number of different unknown factors, what is of interest is the implications of this construction on the subjectivity of the speaker. Enacting resistance to the states of domination, in this case biomedicine, is likely to be experienced as unsettling and disabling as a position of uncertainty is occupied. It might be constructed that the caveat offered through this talk is an attempt to moderate the effects of subjectivity.

Whilst systemic therapy has been constructed to have limitations through this extract, it still offers a form of resistance which serves to highlight the institutionalised nature of certain power relations which constitute states of domination. The speaker's efforts to construct her practice as resisting the dominance of biomedicine can be constructed as an emancipatory effort through the questioning of normalisation and self-regulation.

In summary, this section has presented and discussed the analysis through attending to clinicians' constructions of practice in relation to service context. The clinicians' constructed their practice in a number of ways. These were in relation to the subjugation of women's sexual experience in the context of service provision, the dominance of and processes of resistance to biomedicine in service commissioning, and the effects of governmentality on clinicians practice. The final chapter will offer a summary and evaluation of this research and provide recommendations going forward for clinical research and practice.

CHAPTER FOUR: SUMMARY, EVALUATION AND RECOMMENDATIONS

This chapter evaluates the main findings from the analysis in relation to the research questions. A critical evaluation of the research is presented which considers issues of coherence, sensitivity to context, rigour, transparency and reflexivity (Yardley, 2008). Finally, implications for future research and clinical practice are considered.

4.1. Research Questions and Analysis Summary

The aim of this research was to explore how clinicians working with women experiencing difficulty with orgasm constructed their practice. The research was, therefore, guided by the following questions:

- How do clinicians construct their understanding of practice with women experiencing difficulty with orgasm?
- What impact do the clinician's constructions have on the treatment and embodied experience of women experiencing difficulty with orgasm?
- What are the implications of these constructions for subjectivity and practice?
- How are wider socio-cultural contexts imbricated with this discursive formulation of sexuality?

To answer these questions, and in the interest of clarity and structure, the three discursive sites referred to throughout chapter three will be combined with the main research question to structure this section.

4.1.1. How do Clinicians Construct their Understanding of Therapy with Women Experiencing Difficulty with Orgasm, in Relation to Being a Therapist?

The constructions of the clinicians' practice in relation to their role as therapists saw both clinical psychologists and psycho-sexual therapists talk of their

profession in particular ways by drawing upon particular discourses. These included the use of an outsider discourse to create the subject positions of 'expert' and 'non-expert', and to reinforce their professional status through the process of 'othering'. This attempt to regulate the hierarchical structure and power relations can be associated with a political agenda of professional colonisation and can, therefore, be considered a technology of power. The implication for subjectivity of the clinical psychologists, who were positioned as a 'non-expert', is that they possess less knowledge and, therefore, power. The consequence of occupying a position that affords less professional power may inhibit the profession's ability to enact the change required to challenge the status quo, as their professional voices and recommendations may not be privileged. The analysis presented examples of how the 'non-expert' subject position was constructed as resisted. This was achieved through aligning to a biomedical discourse and we can, in fact, draw upon previous literature and Foucauldian ideas to explore the implications of drawing upon such a discourse. Foucault (1990) asserted that 'norms' are defined through the observation (gaze) and categorisation (archive) of individuals in order to identify abnormalities. The process of seeking and defining homogeneity facilitates the accumulation of knowledge and, therefore, power which affords the subject position of 'expert'. By clinical psychology aligning itself to the dominant biomedical framework, it can be argued that it strengthens its clinical influence and indispensability within psycho-sexual services; a field in which its involvement is relatively recent. Having said that, there exists regulatory processes at the level of the institution, which have been constructed by the participant as prohibitive in their quest to be considered expert and indispensable. The accreditation process affiliated to CBT proficiency is one such example. Clinical psychologists are not automatically accredited upon qualifying which has implications for their subjectivity in that they are constructed as possessing less relevant knowledge which is also less valued by the dominant biomedical framework. This may have negative implications for professional security.

Finally, an economic discourse was drawn upon by clinicians to construct psychosexual difficulties as less important than other mental health difficulties in relation to their economic impact, such as an ability to go to work and be a

productive member of society. The governmental neoliberal regime dictates that success in life is linked to freedom from the state. The requirement to self-regulate one's body to maintain health in order to continue to work and be productive can be understood according to a Foucauldian perspective. He argued that neoliberal forms of governmentality result in social regulation, thus, creating subject positions in which individual agents are forced to conform (Oksala, 2015). By clinical psychology being constructed as failing to provide research which demonstrates the economic impact of orgasm difficulty, and in line with neoliberal forms of governmentality, women experiencing difficulty with orgasm are afforded the subject position as 'less important', while services commissioned to support this presentation are positioned as 'luxury'.

In summary, clinicians constructed their practice with women experiencing difficulty with orgasm in a number of ways. They constructed their practice in terms of pursuing expert knowledge in order to secure funding and influence within psychosexual services. An element of professional competition was evident through these constructions which saw psychosexual therapists and clinical psychologists vying for hierarchical dominance within this field. These constructions were made possible by drawing upon a number of different discourses, such as biomedical and outsider, in order to warrant particular social actions resulting in the assertion of their professional dominance. The deployment of these discourses enabled clinical psychology to align itself to a dominant medical model which privileges objective truth and a CBT approach to therapy. However, in so doing, clinical psychology becomes less competitive as it is not accredited by the CBT regulatory body, thereby diminishing its power. The economic discourse and neoliberal forms of governmentality are used to construct mental distress in terms of an individual's social productivity. As such, female orgasm difficulty is positioned as a complex presentation and one in which research has failed to demonstrate its impact economically. The implications for clinicians, women, and services, under the regulatory power of the biomedical regime, is that this presentation is constructed as 'less important', and a 'luxury'. The implications of this will be further addressed in section 4.4.

4.1.2. How do Clinicians Construct their Understanding of Therapy in relation to the Women who present as Experiencing Difficulty with Orgasm?

The clinicians interviewed for the thesis constructed women who present with difficulty experiencing orgasm as 'problematic' and 'untreatable'. The clinicians gave many reasons for this including; unsatisfactory research into the phenomena; inadequate teaching on professional training courses; and the complexity of female sexuality itself in comparison to that of males. The subject positions for women presenting with this difficulty were, therefore, constructed as 'heart-sink' and 'hopeless', whilst clinicians were constructed as 'failing' and 'unhelpful'. The professional training that clinicians undertake discursively shapes how they conceptualise the client, the presentation, and how they relate to broader practices. In this way, professional training could be considered a purveyor of disciplinary power, in that it uses the technology, normalisation, to stipulate what presentations are considered a priority for training. It is through normalisation and the accumulation of knowledge through defining homogeneity that the biomedical framework asserts its dominance. As such, presentations which are more easily classified, such as 'depression', and which correspond to biomedical treatments like CBT, are privileged by training, whereas presentations that are more 'complex' and 'messy', like difficulty with orgasm, fit less well and are not privileged by training. The effects of this institutional practice diminish the knowledge/power of psychosexual presentations due to the consequential lack of research and psychological interest.

Discourses of male sex drive (Holloway, 1984), heteronormativity and patriarchy are drawn upon in the extracts. These systems of thought, comprised of dominant beliefs and practices, construct women and their sexuality as subservient to men and men's sexuality. Orgasm, in this way, becomes constructed as contingent on penetration, and vaginal orgasm becomes constructed as superior to other expressions of desire and sexual satisfaction. These constructions can also be located in the literature surrounding orgasm function. Through drawing upon empiricist and evolutionary discourses and a scientific approach to the search for knowledge, many researchers (Brody, 2006; Costa, Miller & Brody, 2012; Puts, Dawood & Welling, 2012; Meston et al., 2004) have asserted the importance of vaginal orgasm as the pinnacle of

sexual pleasure and as biologically and evolutionarily necessary. Clinicians' constructions of practice, when aligned to the biomedical model, locates them within an expert position. The expert knowledge drawn upon utilises disciplinary technologies to develop 'norms'. The implication means that women unable to experience orgasm are constructed as 'abnormal'. Clinicians who fail to attend to issues of context, who do not challenge their unhelpful assumptions influencing their practice, could have a significant impact on a client's selfhood. Willig proposes the reason for this may be due to the constructive power of discourses which make available "certain ways-of-seeing the world and certain ways-of-being in the world" (2008, p.113). This may result in a failure to challenge the dominant discourses which perpetuate orgasm difficulty by limiting alternative constructions and counter-discourses. This is an important and novel finding of this research which calls into question the appropriateness of a biomedical treatment such as CBT. Unless clinicians draw upon alternate discourses, this regulatory power manifesting in a pattern of circularity may remain immune to resistance.

Foucault (1978) introduced the concept of biopower, the medicalisation of certain areas of life, for example sexuality, which brought it under scientific control. Biopower can be considered a practice of governmentality as the knowledge it generates acts as an instrument of power to manage the population and support the socio-political control of people in society. This technology of power can be located in the data through many examples, one of which is through the constructions of women's sexuality as 'unimportant' in relation to reproduction. Women do not require an orgasm to procreate, therefore, while they are positioned as 'abnormal' in relation to women who are able to experience orgasm, they are constructed as 'unimportant' in relation to men and the context of procreation.

Additionally, the normalisation of women's sexual experiences can be considered a form of social control (Bordo, 2003) and a way to perpetuate the effects and power of patriarchy; an institutional regime. This can be understood through the clinicians' construction of women's sexuality in relation to reproduction. By drawing upon heteronormative discourses to inform practice, certain subject positions are warranted, such as 'abnormal' if orgasm occurs without a partner, while others are precluded for women seeking support for

difficulty with orgasm. In this way, the vaginal orgasm can be considered a potent signifier of (un)successful women as, according to the rules stipulated under heteronormativity discourse, orgasm is to be 'achieved' through penetration. The construction of women as 'problematic' if they are unable to orgasm, yet 'untreatable' according to biomedically informed treatments, can arguably be said to perpetuate patriarchal power at a macro level. To further elucidate this point, according to heteronormative and patriarchal discourse, orgasm through penetration is key. If a woman is unable to orgasm in this way she is constructed as 'abnormal' and 'problematic' in relation to sexual experience which biologically privileges men's ability to orgasm. The 'problematic woman' remains untreatable because alternate constructions of sanctioned sexual satisfaction that do not involve penetration could potentially impact sexual preferences of men. If clinicians, and possibly women, fail to draw upon counter-discourses and understandings of sexuality to those which are currently dominant, the implications for female subjectivity will remain the same as the regulatory power of patriarchy endures in the absence of resistance.

There are examples in the data where a feminist discourse has been drawn upon to offer a point of resistance to dominant patriarchal and biomedical understandings of female sexuality. The process of resistance constructs feminist approaches to therapy as facilitating a move away from the individualising and pathologising subject positions created by biomedical discourse, towards a consideration of broader contextual factors and alternate sexual scripts. In this way, resistance deployed within a feminist discourse can be understood as seeking to expose the supremacy of biomedicine, as a state of domination (Foucault, 1978), by revealing the institutional nature of certain power relations which perpetuate its regime. In so doing, an alternate way of constructing women's experience of orgasm may be enabled, that is separated from penetration.

In summary, clinicians constructed the women with whom they work in a number of ways. They constructed women's presentation of orgasm absence as 'problematic' and 'untreatable', and the women themselves as 'heart-sink' and 'hopeless'. The subject positions constructed for the clinicians in response included 'failing' and 'unhelpful'. The broader socio-cultural context imbricated

in these discursive constructions included unsatisfactory research into the phenomenon and inadequate professional training. These broader contexts can be understood as institutional practices which regulate research and psychological interest in this area. In terms of the subjectivity of women who are unable to experience orgasm, it can be argued that their distress is manufactured and maintained by these regulatory practices, at the level of the institution, through the deployment of discourses drawn upon by the clinicians in the text, such as patriarchal, heteronormative, etc. This regulatory power is largely uncontested by the clinicians in the data. There are, however, some examples of the construction of resistance to the dominant biomedical model that have drawn upon feminist discourse to integrate socio-cultural contexts within the formulation of female sexuality. These constructions support the work of the New View Campaign (2008), which challenges oversimplified, homogenous and reductionist messages of female sexual experience. The implications of this approach may enable alternate constructions of female sexuality, thus reducing distress.

4.1.3. How do Clinicians Construct their Understanding of Therapy with Women Experiencing Difficulty with Orgasm, in Relation to Service Context?

The provision for psychosexual services was constructed by clinicians as being reduced in a financial context. Throughout the data, examples of institutional practices informed by biomedical and capitalist discourses were constructed, which can be understood as regulating psychosexual services through the practices of efficiency, productivity, objective truth and reductionism. These discourses were not only located at a local level through analysis of the data, but can also be located at a broader, macro, institutional level. The discourses operating at this level have in them ways that construct institutional practices such as the DSM (APA, 2013) and NICE guidance which deploy regulatory practices. These discourses have implications for the subjectivity of clinicians, their practice, and the women who are treated by these services. Clinicians are bound by a complex set of regulatory practices, determined in part by biomedical discourses. As such, certain knowledges and clinical practices become valorised, such as CBT. In this way, biomedicine may be considered a state of domination as its institutional power relations remain obscured by its

pervasive nature, which operates at all levels of context. As such, emancipation from this state of domination towards strategic relations becomes difficult to challenge as applications of normalisation techniques and self-regulation remain unquestioned (Foucault, 1978). At a broader level, the institutional practices constructed through discourses, such as the DSM (APA, 2013), NICE guidance and evidence based practice, maintain the localised discourses, such that the practice of clinicians for the treatment for orgasm difficulty, through the use of sanctioned treatments like CBT, becomes constructed as ineffective. The reason for this may be explained by the reductionist and individualistic nature of CBT which fails to attend to the complexities of female orgasm. The implications for the subjectivity of clients, therefore, by taking up the subject position as 'untreatable', means that they are unable to receive any reprieve from the distress they experience as a result of the discourses which construct their experience.

In terms of service commissioning, this analysis thus exposes an ethical dilemma. Services receive money to provide therapy for women who have difficulty with orgasm. The disciplinary power, however, operating at the level of the clinician means that they are self-regulated to provide a therapy which must adhere to NICE guidance and evidence based standards in order to demonstrate outcome efficacy, as per the effects of institutional power. The ethical dilemma is presented when we explore the constructions of clinicians that the sanctioned therapy, CBT, is constructed as not working. The potential implications of CBT's ineffectiveness are cleverly disguised by its relationship with neoliberalism. An example of this can be seen through the fundamental element of 'homework' that is allocated within CBT approaches to therapy which places some of the responsibility of therapy's success with the client, whom is expected to practice the strategies at home. Thus, if the therapy is unsuccessful, the failure cannot be completely attributed to the clinician.

Through exploring the clinicians' constructions of their practice within a broader context a circular, self-reinforcing, technology of power was evidenced. At a local micro level therapy was constructed as being regulated by evidence based practice, adherence to NICE guidance, with the generation of outcome measures required to evidence efficiency. These constructions are maintained and sustained at a broader macro level, as institutional practices, informed by

capitalist, patriarchal and biomedical discourses. Aspects of these dispositifs¹³, such as the DSM, policy guidance and NICE, create a space in which the clinician's talk is made possible. This process becomes manifest as a state of domination in which the micro and macro discursive practices become mutually reinforcing, obscuring the power relations at play and thus perpetuate the power/knowledge nexus associated with biomedicine.

The construction of psycho-sexual services as a 'luxury provision' reinforces a patriarchal discourse and perpetuates the subject positions afforded to women experiencing a lack of orgasm. That is, women are positioned through this discourse as being less important than men, resulting in the subjugation of their sexual satisfaction when linked to heteronormative practices. The construction of services as a luxury provision is reinforced through an economic discourse in which clinicians talk about how commissioners need to see results demonstrating the efficacy of their work. However, these results are constructed as not forthcoming in relation to working with presentations such as women experiencing orgasm difficulty. As such, clinicians construct their practice as existing within a double bind; they want to utilise therapeutic approaches which privilege context, however, are seduced by the need to produce data and statistics derived from utilising a CBT, biomedical and realist framework.

There were examples in the data of clinicians constructing their practice as resisting the dominant medical model. They constructed a challenge of balancing the requirements of the service and commissioners, with the needs of the clients. In terms of meeting service need, Foucault's (1979) concept of governmentality can be drawn upon usefully here. It also helps us to understand the process by which CBT remains the 'gold standard' therapy, despite its poor efficacy record in terms of orgasm work. Broader institutional practices, such as clinical guidance, can be said to regulate the actions of the clinicians through processes of self-regulation. This regulatory power at the level of the institution ensures social control through the continual processes of evaluation, observation, audit and inspection of clinicians work. As such, the

¹³ "The various institutional, physical and administrative mechanisms and knowledge structures, which enhance and maintain the exercise of power within the social body" (O'Farrell, 2007). Also referred to as apparatus.

conscious awareness of surveillance is internalised by the clinicians resulting in self-disciplining behaviour in order to avoid sanction. The implications for subjectivity, therefore, of taking up the subject position as CBT therapist, mean that the clinician inevitably sees the world from that vantage point. Arguably, this limits their formulation and understanding of the women's presentation and perpetuates the power/knowledge in biomedicine.

The alternate discourses drawn upon in the data, to resist the dominant constructions of female sexual experience, were primarily feminist discourses. They were employed to construct systemic therapy as a useful alternate approach to CBT. These feminist, emancipatory, discourses make available alternate ways of understanding the world that take into account contextual factors. Compared to CBT, systemic therapies are constructed as disadvantaged in the data in terms of power/knowledge, as they do not operate within the same knowledge claims of the biomedical model and, therefore, cannot be considered competitive when evaluated within the scientific criteria advocated by an economic and biomedical discourse. The implications of this, therefore, means that women are less likely to receive support which attends to contextual factors and rejects the pathologising and individualising constructions currently set up through biomedicine.

In summary, clinicians construct their practice within broader service context in a number of ways. They construct their practice in terms of balancing the needs of commissioners and clients, both of whom are constructed as requiring different and perhaps conflicting agendas. Clinicians work can be understood as part of a bigger picture, whereby broader institutional practices are sustained and maintained through processes of disciplinary power to reinforce the power/knowledge nexus of the dominant biomedical model. Alternate discourses of resistance and feminism are constructed within the data to promote systemic therapeutic approaches to this presentation. As they do not subscribe to the same knowledge claims to that of biomedicine, they are unable to demonstrate their efficacy and thus their power/knowledge is moderated. There are implications for women, clinicians and services if therapies which account for socio-political and contextual factors whilst providing space in which to construct an alternative account of female sexual pleasure are not privileged. It is likely that service funding will continue to reduce which will further

propagate the message that female satisfaction is less important. This may result in only the most complex of presentations being accepted for treatment, which will be even more difficult to 'treat'. The way out of this impasse shall be further explored in section 4.4.

4.2. Evaluative Criteria and Critical Review

This section evaluates the findings of this research study, specifically in relation to its validity, application and trustworthiness. It takes inspiration from the evaluative 'toolbox' presented by Yardley (2008) and considers the coherence of the thesis, its sensitivity to context, issues of rigour and transparency, reflexivity, and impact.

4.2.1. Coherence

This research sought to clarify the relevant theoretical and empirical literature in order to formulate an appropriate, and previously unanswered, research question. This is important in order to demonstrate the validity of the project through considering sensitivity to context¹⁴ (Yardley, 2008). The coherence of a study is judged on its ability to provide a convincing and lucid argument which is, in turn, determined by the interrelation of the theoretical approach, research question, methodology and analysis (Yardley, 2008). I have attended to the evaluative criteria of coherence herein by readdressing the research question, reviewing the literature in conjunction with providing an analysis summary and thesis argument¹⁵

The processes and stages of analysis were labour intensive and involved operating at a micro and macro level. The coherence of the analysis and integration of literature has been demonstrated through three discursive sites. These sites present the myriad ways in which clinicians constructed their practice to ensure clear links between extracts and discursive constructions were evident¹⁶.

¹⁴ See section 2.7.2.4. for more information about sensitivity of context.

¹⁵ See section 4.1.

¹⁶ See methodology chapter for how these discursive sites were identified.

4.2.2. Sensitivity to Context

Throughout this thesis I have endeavoured to present new understandings of the way orgasm is constructed by clinicians, by considering the contextual and temporal interactions throughout my analysis. Therefore, the findings presented in this thesis have been constructed throughout the process of completing this research, and have not, in any way, been stipulated in advance. This motivation to allow the generation of new meaning through research is considered to be a key characteristic of qualitative research and vital in demonstrating its 'validity' (Yardley, 2008). A significant attempt has been made throughout the research process to attend to my position, and the implications to subjectivity thereof. These considerations are reflected upon in detail in section 2.7.2.4 and have thus been omitted herein in the interest of avoiding repetition.

4.2.3. Rigour and Transparency

The transparency of a research project can be demonstrated through the presentation of a clear and coherent argument which provides sufficient details of the methodology used. Yardley (2008) proposes that transparency is demonstrated through a 'paper trail', which remains unpublished, but should be available to others by request. The 'paper trail' documents that the research has been conducted professionally¹⁷.

Yardley (2008) argues that in order to achieve rigour in qualitative studies, one must attend to the data thoughtfully and with sufficient methodological skill and theoretical depth. This was achieved through requesting a supervisor whom I knew had extensive experience with this methodology, and also through peer supervision with fellow trainees, who were also using a Foucauldian informed methodological approach.

4.2.4. Limitations of the Study

The processes of participant recruitment were discussed in section 2.7.2.2 which explored the implications for recruitment resulting from a reduced number of clinicians working in this area. Had recruitment been started earlier, and perhaps extended to outside of the London area, then it may have been

¹⁷ see appendix 7 for examples of the analysis forming part of the paper trail

possible to recruit a more diverse professional population. It may also have been possible to use focus groups, rather than semi-structured interviews, to collect the data. This would have resulted in more naturalistic conversations and would also have minimised my influence over the data as a researcher.

Ultimately, the methodological approach adopted throughout this thesis permitted the exploration of certain ideas, such as power and subjectification, yet precluded others. An area that was not possible to explore included the opportunity for clinicians to discuss their lived experience of taking up certain subject positions. As such, the data could be revisited through an Interpretative Phenomenological Analysis (IPA) lens, as per Colahan, Tunariu and Dell (2012).

4.3. Reflexivity

4.3.1. Epistemological Reflexivity

Considering how a Foucauldian approach to research is interested in how language influences the construction of social and psychological life (Willig, 2008), this thesis must itself be acknowledged as a discursive construction. As such, it has been imperative that I maintain a reflexive stance throughout my engagement with this research process, and attend to the impact of my authorship on the construction of this particular knowledge. Questions have been asked of the data to explore how particular versions of therapy for women experiencing an absence of orgasm have been constructed through language. In this way the research has not assumed that there is a 'true' version to be 'uncovered'. Rather, the knowledge produced in this research has explored multiple constructions of reality, each constituted through the historical social and psychological effects of discourse, and the implications for subjectivity.

To date, I have found no research exploring clinicians' constructions in this clinical area. Consequently, this research took an exploratory approach to the topic to facilitate a general understanding in this area. While alternative approaches to the study of this area could have been adopted, they would not have corresponded with the research questions or aims of the study, and thus,

would have shared incompatible assumptions in relation to the quest for knowledge production.

4.3.2. Personal Reflexivity

Willig (2008) quantifies 'good' qualitative research in terms of the reflexive consideration of the researcher's role in shaping the research process and, thus, the object of inquiry. As such a personal reflection of the research process shall be attended to herein. My clinical and research experience has shaped the way that I understand the absence of orgasm. I would argue that the current and dominant understandings of the presentation which is categorised as 'female orgasmic disorder' and subsequent treatments, are somewhat ineffective. As a soon-to-be-qualified clinical psychologist with a special interest in the area of psychosex, I experience this as disheartening. I had hoped that this research would have more of a clinical impact, or significant emancipatory value, than it has. As such, I have experienced this process, somewhat ironically, as anti-climactic. My belief is that the discourses currently drawn upon to construct our understanding of this presentation perpetuate the 'problem' and offer no solution to the distress they cause.

Throughout this research process I found it all too easy to become caught up in expert discourses which stemmed from the reading and formulating about 'good' and 'bad' treatments for this presentation. This position was seductive as the 'knowledge' gave me (much needed) confidence in the context of working as a trainee clinical psychologist, unskilled in the psychosex field. It was only through supervision and a committed engagement with poststructuralist literature and associated methodologies that I was able to resist this position, by drawing upon alternative and perhaps more emancipatory discourses, such as feminism. Additionally, I also noticed how difficult it was to resist dominant constructions of orgasm such as 'the orgasm imperative' (Potts, 2000); the idea that orgasm *is* something fundamental to sexual satisfaction and the pinnacle of sexual relations. These inherent assumptions inevitably slipped into my clinical practice through the allocation of homework and, regrettably, recommendations of the application of directed masturbation. I hope this reflection demonstrates just how hard it is to resist the dominant constructions of orgasm that so insidiously influence clinicians assessments, formulations, treatments and

evaluations of practice. That even for someone researching and working clinically in this area, I was not immune to the regulatory processes.

4.4. Impact and Recommendations

4.4.1. Implications for Future Research

Further research that propose emancipatory aims would be useful to counteract the dominance of realist claims to knowledge currently privileged in female sexual satisfaction research (Lavie & Willig, 2005). The utility of further postmodernist contributions in this clinical area would refocus the emphasis towards the effect of language and its role in the subjective experiences of women's pleasure, as recommended in Lavie and Willig's (2005) study of women's experience of 'inorgasmia'. It is recommended, therefore, that more exploratory, emancipatory and qualitatively focused research be conducted, especially in relation to women's experiences of therapy when presenting with an absence of orgasm, as well as non-clinical populations in order to broadly examine the effect of discourse at the level of the women in the context of sex and orgasm.

Whilst this research has focused on using the methodological approach of FDA, the discourse analysis has been located at the level of the interview transcript. Attempts have been made to locate this talk within the broader institutional practices that make certain discursive practices possible, for example inadequate professional training. From the analysis we can see that a tension has been constructed. We can conclude that mainstream, CBT, treatments for orgasm difficulty are not efficacious, however, services continue to receive funding regardless, in part because of the need to adhere to evidence based practice. It is, therefore, recommended that this ethical dilemma be addressed further by exploring the institutional technologies that make available these ways of being, through a Foucauldian genealogy. This methodology would allow for the examination of such things as, for example, how psychosexual clinics have come to have as their purpose that which they are patently constructing as not working.

The consideration of what has *not* been talked about or constructed by the clinicians has opened up some interesting questions. The analysis has examined many constructions of orgasm absence as located within biomedical, heteronormative and patriarchal discourses. While this research has sought to expose the technologies of power which regulate these constructions, and the implications for subjectivity on the women who self-identify with this presentation, the clinicians did not construct an alternative way that orgasm absence can be understood. This void may inform future research such as to explore how else sexual satisfaction can be constructed. As per the theoretical underpinnings of FDA (Willig, 2008), the dominant constructions presented herein are only one way of understanding the phenomenon of orgasm. If orgasm can become separated from the scripted regulation of heteronormativity, experienced as orgasm through penetration, sexual satisfaction may become multifaceted and very different for different people, thereby rendering the distress associated with the 'abnormal' subject positions created through technologies of normalisation as extraneous.

4.4.2. Implications for Clinical Practice

Clinical psychology is a discipline which can be located primarily as working within a biomedical framework (Rohleder, 2012). The majority of clinicians working in the field of psychology are constricted, and limited, by the pervasiveness of a system and the assumptions within which they operate. The dominance of a cognitive behavioural therapeutic (CBT) approach within sexual health psychology can be evidenced in the systematic review completed by Laan et al. (2013). Their findings endorsed CBT as the 'gold standard' treatment for women experiencing difficulty with orgasm. On closer inspection, however, there were significant weakness in the studies (Heiman, 2002). CBT has emerged from a Eurocentric and reductionist approach towards scientific knowledge which asserts that there are objective truths to be known (Boyle, 2011). This raises questions about the suitability of an approach whose epistemological assumptions violate the results from an extensive body of literature on female sexuality which advocates a biopsychosocial approach to female sexuality (The New View Campaign, 2008).

The construction of orgasm, and its absence, has implications for the way clinicians work with women experiencing difficulty with orgasm. As a

phenomenon which is dominantly constructed as pathological and problematic, its conceptualisation through research, treatment and therapy can be said to reinforce the reproduction of biomedical forms of knowledge. There appears to exist many ways to approach the phenomenon of distress associated with orgasm absence. Two obvious approaches could involve *either* changing the way society/clinicians/women conceptualise orgasm and its role in sexual fulfilment, *or* developing a new treatment which will work to satisfy those women in distress as result of not experiencing orgasm. Indeed it is not my role as researcher to assert a 'right' way, only to present consequent recommendations which are grounded in the theory and the data. Perhaps, though, it is not a case of *either/or*, but rather, *both/and* (Burnham, 1992), a systemic position which can attest the integration of the best parts of disparate approaches, modernist and postmodernist, to arrive at a better story position (Pocock, 1995).

Guideline: The focus of the intervention should be on competencies and strengths, rather than individual deficits.

Recommendation: A focus on deficits perpetuates the notion that the 'problem' is inherent, thus, in order to resist the constitution of this subject position, a solution focused approach could be utilised which attends to the power of language in the construction of our social realities (de Shazer et al., 2007). The focus on this approach is future-based and works towards identifying any unique exceptions when a client's goals have been achieved to a certain degree. Therapeutically, and in the context of work with orgasm difficulty, this may involve exploring with a client when they have experienced instances of sexual satisfaction, thus removing the focus on 'achieving' orgasm. The hope is that by strengthening those experiences, the focus on their individual failures and pathologies will be minimised. This approach may also alleviate distress by asking 'exception questions' such as, 'when has sex been satisfying for you?' This approach is based upon social constructionism and privileges the effect of language (de Shazer et al., 2007) and, as such, it assumes that language can shape our reality. In this way, it can be considered conducive to the identification of alternate discourses as it shares a similar epistemological stance.

Guideline: The intervention should take a preventative approach

Recommendation: The educational system could focus on providing a sex education inclusive of sexual pleasure. This approach could challenge the assumptions of heteronormativity and patriarchy by resisting dominant discourses thus making available alternate constructions of sexual pleasure, such that orgasm through penetration does not indicate the pinnacle and end point of sex. In so doing, a preventative approach would resist the 'normal/abnormal' subject positions as determined through normalisation, thus reducing the distress associated with assuming the latter position. While sex and relationship education is compulsory from age 11 onwards, a study by Wight (2011), in which he evaluated three different sex education programmes, found that broader social factors are more influential in shaping behaviour, such as socio-economic factors, parent/child relationships and the effect of sexualised and violent culture in mass media. He asserted that addressing these factors is likely to have a greater effect on sexual outcomes than the further development of traditional sex education. Broadening the focus of sex education away from contraception and sexually transmitted infections (both which can be said to perpetuate heteronormative discourses) towards alternate experiences of pleasure and intimacy, could offer an emancipatory and liberationist framework within which to privilege alternate constructions of sexual function. Whilst I am advocating for a preventative approach for this particular phenomenon, it can also be said that a preventative approach across all mental health concerns would be beneficial. That is the position taken by community psychology, whose fundamental principle is centred on prevention (Nelson & Prilleltensky, 2010).

Guideline: The type of intervention should involve social action and community development.

Recommendations: Therapeutic groups which adopt a collective narrative practice methodology involve the sharing of stories and skills. It enables communities to share successes and join together in mutual support and strength. Collective narrative documents can be produced to describe the thoughts of individuals, groups or communities who have been able to resist the subjugation of punitive and damaging discourses. These can be shared in a number of ways to enact social action thus empowering wider communities affected by similar struggles (Dulwich Centre, 2016). In terms of

women's experience of orgasm difficulty, this type of approach may provide a space whereby the discourses maintaining the subject positions of 'problematic/abnormal' can be challenged and resisted. Based upon this research to date, and my clinical experience, I would anticipate that the opportunity to hear other cultural constructions of orgasm and sexual satisfaction could be offered as a process of resistance. Through these processes, and the power of collective voices, the strengthening of alternative positions may be enabled.

4.4.3. Supervision and Reflexive Practice

The process of supervision as a therapist is vital to explore the impact of the different contexts one may be acting from and in to (Pearce & Cronen, 1980), as well as the assumptions one carries which might influence one's practice (Selvini, Boscolo, Cecchin & Prata, 1980). Supervision and the engagement of reflective practice are vital components within therapeutic professions (British Psychological Society, 2008). Supervision should provide the space for clinicians to reflectively consider the issues raised in this thesis, and the processes of power which may be influencing their work, as was found in this research. The consideration of how social discourses are imbricated in the construction of psychological knowledge and practices would allow clinicians to consciously consider their position in relation to their work with women and the wider service contexts within which they are located. Through open and honest supervision and reflection, clinicians would be able to consider the effects of governmentality on professional practice which might facilitate alternative constructions of the difficulty as well as affecting the implications for subjectivity.

4.5. Final Thoughts

This study has examined the way clinicians construct themselves, their practice, their clients who present with orgasm difficulty and the wider service context within which they are positioned. I hope that through adopting a Foucauldian informed analysis of the data new insights have been presented which may

open up opportunities for resistance to the dominant and unhelpful way of attending to this 'problem'. I would like share the thoughts of one of my participants, who I think, rather articulately, summarises the essence of this thesis.

02FClinPsy:... *I think so much of the importance is the talking, the stories, you know, how we language these things. How do we language it in a way that's accessible to people, meaningful to people, and I think if you say to most women you're here because of an, anorgasmia or orgasmic disorder or something, it's, you know, you're immediately putting up a barrier and also kind of implicitly stating what where the problem is, you know, yeah I mean you could just as easily call it, I don't know, patriarchal disorder couldn't you or like (laugh), you know, who cares about women's sexuality disorder (626-634).*

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APPENDICES

Appendix 1: University of East London Ethical Approval

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Pippa Dell

REVIEWER: Trishna Patel

STUDENT: Joanne Adams

Title of proposed study: Mental Health Professionals' constructions of practice in relation to working with women experiencing female orgasmic disorder.

Course: Professional Doctorate in Clinical Psychology

DECISION (*Delete as necessary*):

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will

be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required (for reviewer):

- 1) Please ensure that the submission date (section 1.3) is that of the thesis hand-in, in which case, it should read **May 2016** instead of February 2015.
- 2) Section 2.2 states that data collection will end in July 2015, this does not allow much time for data collection. I would strongly advise that this be changed to **April 2016**, to avoid seeking approval to extend the period for data collection.
- 3) Section 2.7 needs to clearly identify each step involved in the procedure from the point of contact with the service/service manager to your final contact with participants. As it stands, this is not sufficiently communicated within this section. For example, permission will be sought from service managers, in what form, will you meet with them, how will information be circulated to the team, you state holding an initial meeting for potential volunteers but then include the interview in this, will there be two meetings, or just one?
- 4) Within section 3.4.2 please include the amount of time you will store data for before destroying it and where information will be securely stored (e.g. home of the researcher, at UEL).
- 5) The current formatting of the information sheet is visually difficult to digest, consider left aligning.
- 6) Section titled '*confidentiality of the data*' within the information sheet should include how long you will keep data for and list publications when discussing where data will be anonymised.
- 7) The final date to withdraw from the study is not communicated in the information sheet but is mentioned in the consent form; please ensure this information is provided in written form within the information sheet.

Major amendments required (for reviewer):

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. I have also discussed these with my director of studies.

Student's name (*Typed name to act as signature*): Joanne Adams

Student number: u1331667

Date:

03/03/2015

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

☐

MEDIUM

☒

LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature):*

Dr Trishna Patel

Date: 03/03/2015

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here:

<http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

Appendix 2: Application to Change Registered Title of Thesis for a Postgraduate Research Programme



Quality Assurance and Enhancement



APPLICATION TO CHANGE THE REGISTERED TITLE OF A THESIS FOR A POSTGRADUATE RESEARCH PROGRAMME

(TO BE COMPLETED BY THE DIRECTOR OF STUDIES AND THE STUDENT)

In completing this form you should refer to the relevant sections of the Research Degree Regulations (Part 9 of the UEL Manual of General Regulations) and the UEL Code of Practice for Postgraduate Research Programmes.

This form must be signed and dated in advance of submission to School Research Degrees Sub-Committee (SRDSC).

1. STUDENT'S DETAILS

FULL NAME	Joanne Adams	
UEL STUDENT NUMBER	U1331667	
CURRENT MODE OF STUDY (DELETE AS APPROPRIATE)	FULL-TIME	
PROGRAMME FOR WHICH YOU ARE CURRENTLY ENROLLED (Please Tick)	MPHIL	
	MPHIL BY PUBLICATION	
	PHD VIA MPHIL	
	PHD DIRECT	
	PHD BY PUBLICATION	
	PROF DOC	X
	PHD (EUR)	

TITLE OF PROFESSIONAL DOCTORATE PROGRAMME (IF APPLICABLE)	Doctorate in Clinical Psychology
TITLE OF THESIS CURRENTLY REGISTERED	Mental Health Professionals' Constructions of Practice Relating to Women Experiencing Female Orgasmic Disorder
SCHOOL	Psychology
NAME OF COLLABORATING ESTABLISHMENTS (IF ANY)	

2. PROPOSED CHANGE IN THE TITLE OF THE THESIS

PROPOSED NEW TITLE OF THESIS	Therapists' Constructions of Practice in Relation to Women Experiencing Orgasm Difficulty: A Foucauldian Discourse Analysis
REASON(S) FOR THE PROPOSED CHANGE	<p>The term therapist is more appropriate than mental health professional.</p> <p>The label 'Female orgasmic disorder' might be contested in the research so I wanted to use something more neutral and less labelling</p>

3. RECOMMENDATION OF THE SUPERVISORY TEAM

PLEASE NOTE THAT IN SIGNING BELOW THE DIRECTOR OF STUDIES INDICATES THAT THIS IS ON BEHALF OF, AND FOLLOWING CONSULTATION WITH, THE ENTIRE SUPERVISORY TEAM.

PLEASE NOTE THAT ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE

WE RECOMMEND THAT THE CHANGE IN THE REGISTERED TITLE OF THE THESIS SHOULD BE APPROVED AS REQUESTED		
DIRECTOR OF STUDIES	SIGNED: (TYPED NAME TO ACT AS SIGNATURE) DR PIPPA DELL	
	PRINTED:	DATE: 07/03/2016

4. STUDENT'S CONFIRMATION

PLEASE NOTE THAT ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE.

HAVING DISCUSSED THE PROPOSED CHANGE OF TITLE WITH MY SUPERVISORY TEAM, I AM SATISFIED WITH THE PROPOSED CHANGE		
STUDENT	SIGNED: (TYPED NAME TO ACT AS SIGNATURE) JOANNE ADAMS	
	DATE: 07/03/2016	

PARTICIPANT INVITATION LETTER

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator

Contact Details: Joanne Adams - u1331667@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider when deciding to participate in this research study. The study is being conducted as part of my Doctorate in Clinical Psychology degree at the University of East London.

Project Title

Mental health professionals' constructions of practice in relation to working with women experiencing difficulties with orgasm.

Project Description

The aim of this study is to examine how mental health professionals construct their practice in relation to working with women experiencing difficulties with orgasm and the implications of these constructions on clinical practice. Participants will be asked to discuss this topic during a conversational interview with myself. Interviews will last for 40-60 minutes.

Confidentiality of the Data

The data generated in the course of this research will be retained in accordance with the university's Data Protection Policy. Names and other contact details of participants will be kept securely in a location only accessible to myself. All identifiable information including names, service information and locations, will be anonymised, both in the transcripts and the final report. The Director of Studies and examiners will only read extracts from the anonymised interviews. Upon completion of this study, in May 2016, all audio recordings will be deleted however the research may be developed for publication and so electronic copies of the anonymised transcripts will be kept securely. The standard limits of confidentiality applies, where disclosure of imminent harm to self and/or others may occur. This will be discussed in more detail if appropriate.

Location

The interviews will be held in a private room at your place of work.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. The final date to withdraw from this study will be 1st January

2016. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor, Dr Pippa Dell, School of Psychology, University of East London, Water Lane, London E15 4LZ. Email address: p.a.dell@uel.ac.uk

Or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

If you have any concerns about the conduct of the researcher, or any other aspect of this research project, then please contact researchethics@uel.ac.uk

Thank you in anticipation.

Yours sincerely,

Joanne Adams

CONSENT FORM



Consent to participate in a research study

[Mental health professionals' constructions of practice in relation to working with women experiencing a lack of orgasm.]

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

Appendix 5: Semi-structured Interview Schedule

INTERVIEW GUIDE

Thank you for agreeing to participate in this interview. There are no right or wrong answers, I am just interested in your thoughts about women experiencing difficulty with orgasm, and how clinical psychology/psychosexual therapy understands their experience. I will ask you some questions, but I am more interested in letting our discussion evolve. I am more interested in hearing from you and your thoughts. I might try to speak less than would be expected in a typical conversation. You can also feel free to talk about other things I have not mentioned, does that sound ok? Do you have any questions you would like to ask me before we start? Please remember that if you need to take a break at any time or would like the interview to finish, we can stop at any time.

Person questions

- Motivation for volunteering as a participant
 - Why did you agree to take part in this research project?
- What contributed to your decision to work in sexual health services?
 - More specifically, with women experiencing sexual difficulty
- Personal experiences of working with women experiencing sexual difficulty?

Professional questions

- General questions about work with clients
 - Tell me about your work with clients
 - Why is your work important/how does it help them/what effect does it have?
 - Main issues/challenges vs. successes/benefits
 - What do you think your clients appreciate in you as a clinician
- Preferred approaches (what frameworks inform your practice)
- Effect of NHS/NICE/Commissioning/service structure/evidence base on clinical work
- Professional reflexivity
- Understanding of the diagnosis, female orgasmic disorder
- Gender differences
- Views of different types of psychological support available. What do they offer different?
- Role of supervision/support

Contextual questions

- Culture/media effects on societal attitudes towards sex
 - Does this differ between men/women?
 - How do you know this?
 - What do you think has influenced the way you conceptualise your work?
- Formulation

- Does the aetiology of the 'problem' affect your formulation and approach
- Social GRRAACCCEESS – Gender, Race, Religion, Age, Ability, Class Culture, Ethnicity, Education, Sexuality, Spirituality
- Effects of labelling

Follow up questions

- You said X, what makes you say that?
- Where did you learn/get that idea from?
- When you said X, what did you mean?
- You mentioned X, can you tell me some more about that
- Why do you believe that is important
- How do you know that it is important?
- How is this made possible
- Is there anything else you would like to talk about that I have not asked?

Ending

- 5 minutes left, what do you think about what we've talked about?
- Is there anything else that you feel you would like to add?
- What was the interview like for you?
- Do you have any questions for me?

Re-establish consent.

Appendix 6: Transcription Conventions for Interview Transcripts

Code	Description
[laugh]	To indicate laughter
[?]	Inaudible speech
[pause]	Pause in talk of more than two seconds

Key for Coding Transcripts

The number indicates each separate interview and are labelled chronologically in the order they took place.

The first letter (F/M) represents the participant's gender.

The following combination of letters represents the participant's profession:
ClinPsy = Clinical Psychologist, PsySexT = Psychosexual Therapist

E.g. 01FClinPsy = Female Clinical Psychologist

Appendix 7: Visual Representation of the Coded Text

83 would get over even work with families or in certainly much much less than you'd get in one to one
84 work, so I don't know shall I, erm, I could, is it useful for me to hypothesise why I think that it?

85 I: yeah, absolutely

86 K: ok, so erm, evidence base, less clear cut, erm, with the up rise of CBT therapies etc etc we need to
87 be able to compete although ironically we can't because we're actually not considered as good and
88 we don't have BABC accreditation with that, that hasn't really worked very well. Erm, one to one
89 work, stuff that's easy to label; depression, anxiety, is clearer-cut, I think evidence and research has
90 been a bit better at demonstrating how that affects what society is interested in like functioning and
91 going to work etc etc. I think people in the field, including myself, haven't been that good at
92 demonstrating that if there's dissatisfaction in a couple relationship, or sex isn't going well by
93 yourself or in the context of partners, then that has a knock on effect on self-esteem, on depression
94 and anxiety and other stuff that people are actually quite interested in, so I think it's just that it
95 hasn't been very well linked and it's seems a bit precious, a bit icing on the cake, a bit separate to and
96 I felt that was replicated though loads of ways that things were formulated that very very rarely in
97 any formulation that we had, in at least the first 18 months of training, included really genuinely
98 thinking about the partner or quality of relationship, quality of communication, quality of sex life,
99 sex life by oneself, it was only if the other partner's got a significant mental health or personality
100 disorder that it's in any way included, so I guess throughout all of the training, all of the other things,
101 it's an add on, and so it's, people don't, trainees don't think that they need it as in all of the, I guess,
102 all of the establishments kind of reinforce that ideas, as in all our experiences they would have ever
103 had, that supervisors been uncomfortable talking about sex, and couple don't formulate so it
104 doesn't get replicated in the, trainees don't see it as a need, they're not asking for it usually, and
105 training people don't think it's important because if you don't ask a client you're probably not going
106 to hear about it so you think you've done a great piece of work and you got away with never having
107 to say the word sex. So I think it's all sorts of, I guess, historical reasons of what we think a good
108 therapist is and what will they talk about, and I guess it's also a model thing, that psychodynamic
109 would say stuff around sex even if I don't necessarily adhere to a lot of what they would say, I guess
110 it was sexier, sexy, erm, but that isn't as privileged now as CBT above it because of how we think
111 good therapy looks and there's NICE guidelines, RCT's blah blah blah blah. I didn't even realise I
112 thought all that, erm, and I guess it just feels tricky in terms of where trainees are that, I know it's a
113 vigorous process but I do think, like, I definitely had loads of lectures which I could have just read.
114 Like with CBT I don't need a person or somebody telling me how to do a behavioural experiment, I
115 am adult enough to be able to read that book whereas I think a lot of people need that information
116 about how to do stuff, whereas with couples it just isn't clear cut, there just isn't the protocol,
117 there's no clear chapter you can read and it makes perfect sense and I think it's something about
118 feeling useful and good and safe and erm, secure and it gets tagged on like we get half a day. I do
119 the lecturing for UCL and that's literally like half day on sexuality so it's a completely separate area,
120 half day on sexual health, erm, and we're pushing for sexual difficulties and out of our teaching
121 we've not requested gender because before that they didn't think gender was a thing that needed
122 to be touched on and I said in sexuality I can't talk about that because there isn't enough time, so it
123 just feels a tack on, an add on, a comprise, but err, I said loads there, but

124 I: no I know

125 K: I'm not going to enjoy your transcribing job, sorry

126 I: (laugh) yeah its really difficult because a lot of the things that you're saying I personally agree with
127 and erm, then I'm at this quandary of for the purposes of analysis do I need you to elaborate on any

Appendix 8: Stages of Analysis

Stage of Analysis	Description
1. What is being constructed?	This stage involves a thorough exploration of the discursive object as per the research question.
2. How is it being constructed and problematised?	What are the different constructions that are presented in the data? What discourses are drawn upon to make these constructions possible? How are constructions problematised? (Problematisation refers to the construction of the discursive object as 'problematic' and, thus, knowable and visible. The problematised discursive object is a product of the intersection of alternate discourses. They reveal knowledge/power relations.
3. Functionality of the construction	Questions are asked of the data, which include; How is the discursive object being made a problem? What actions can be achieved through the different constructions of the discursive object? How do these discourses problematise function?
4. Identification of discursive subjects	This stage requires the consideration of the subject positions available resulting from the different constructions of the discursive object.
5. Processes of subjectification	This stage involves a exploring the implications for subjectivity; what can be experienced as a result of assuming various subject positions. It is concerned with the relationship between discourse and subjectivity. As discourses make available "certain-ways-of seeing the world, and certain-ways-of being in the world" (Willig, 2008, p.113), they can be said to construct social and psychological realities. Once having assumed a subject position as one's own, a person is constrained to see the world through the lens of that particular position.
6. Technologies of power and implications for social practice	As discourses warrant social action, what can be done, said and gained from within different discourses and different constructions of the discursive object at particular points of the text? What are the different 'technologies of power/self' evident in the text and how are they used.

